AMERICAN BENEFITS GROUP

RECURRING PREMIUM REIMBURSEMENT REQUEST FORM

Participant Name: _____ Last Four Digits of SNN:_____

Participant Address: _____

Phone Number: _____ Email Address: _____

Employer Name: _____

The person named above is a participant in the Retiree HRA plan. Through this plan, recurring medical premium payments may be reimbursed on a tax-qualified basis. You need to provide proof of the insurance premiums and a completed *Recurring Premium Reimbursement Request Form*. American Benefits Group (ABG) will automatically reimburse your recurring payment for the entire plan year.

The participant hereby directs ABG to deduct the amount below from his/her Retiree each period until one or more of the following occur.

- The participant drops/adds/modifies existing expense and the participant provides written direction to ABG to cease such recurring payments
- The end of the plan year

The automatic payment process does not extend beyond one year from the beginning month. You will need to complete a new *Recurring Premium Reimbursement Request Form* along with proper documentation for the new plan year.

Recurring Premium

Description	Period	Beginning (month/year)	Ending (month/year)	Amount
	☐ quarterly ☐ monthly			
	☐ quarterly ☐ monthly			
	☐ quarterly ☐ monthly			
	☐ quarterly ☐ monthly			
			Total Premiums	

I understand that plan distributions will be based on the amount available in my plan account and the expenses submitted for reimbursement. I understand that it is my responsibility to inform ABG, the plan administrator, if my premium changes, as compared to the amount shown above. I understand I must provide written documentation if the periodic amount to be reimbursed changes. I accept full liability for timely notification of any changes.

I have read the above and understand, and verify that, as a participant in the Retiree HRA plan, I incur recurring premium expenses.

Participant Signature: _____ Date: _____

Fax: 877-723-0147 • Email: claims@amben.com
Mail: American Benefits Group • PO Box 1209, Northampton, MA 01061-1209
Tel: 800-499-3539 • www.amben.com

IMPORTANT

If you submitted a ***Recurring Premium Reimbursement Request Form*** the automatic payment process does not extend beyond one year from the beginning month.

You will need to complete a new form (reverse side) and submit along with proper documentation for the new plan year.