Systematic Premium Reimbursement Form

E-mail, fax, or mail completed form and itemized verification to third-party administrator.
Instructions on reverse.

Montana VEBA HRA Third-party Administrator | Rehn & Associates
PO Box 5433 | Spokane, WA 99205 | Phone 1-800-832-2101 | Fax (509) 535-7883
E-mail montana@rehnonline.com

MONTANAVEBA
HEALTH REIMBURSEMENT ACCOUNT

1 PARTICIPANT PERSONAL INFORMATION

Last Name _____ First Name _____ Participant Account No. or SSN _____

Mailing Address _____ ☐ Check here if new address City _____ State _____ Zip _____

E-mail Address (home or personal recommended) _____ ☐ Check here if new e-mail address (_____) _____ Area Code and Phone No.

2 SYSTEMATIC PREMIUM REIMBURSEMENT INSTRUCTIONS

You must attach documentation which includes the following: (1) name(s) of covered individuals; (2) premium amount(s); (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. **NOTE**: Premiums paid by an employer, or premiums that are or could be deducted pre-tax through a section 125 cafeteria plan, are not eligible for reimbursement.

This is a (check one): ☐ New reimbursement ☐ Change to existing reimbursement

1. Date first reimbursement should be received: _____
2. Effective date of insurance coverage change: _____
3. Amount of reimbursement $_____ Frequency (check one): ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
4. Is policy in your name? ☐ Yes ☐ No If premium is for a policy that is not in your name (such as your spouse), please list his/her name, SSN, or policy number.

   Name:_____ Policy No. or SSN:_____

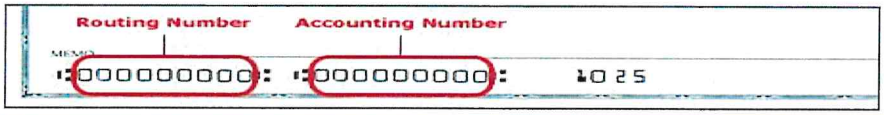
3 DIRECT DEPOSIT ENROLLMENT

If you are not already enrolled in direct deposit, systematic premium reimbursement will be mailed to you via paper check. Information you provide below will supersede any previous direct deposit enrollment on file. For direct deposit to a **checking account**, a voided check must be attached for routing and account number verification. For direct deposit to a **savings account**, please contact your financial institution for routing and account number verification if a voided check is not available.

Account type (check one):
☐ Checking account
☐ Savings account

Name of financial institution (bank or credit union) _____

9-digit routing/transit number _____ Account number (do not include your check number) _____



4 AUTHORZING SIGNATURE

I (participant) hereby authorize the third-party administrator (TPA) to disburse funds from my participant account as provided for in this form. I understand this systematic premium reimbursement authorization will remain in effect until my account is depleted or cancelled by written notice from me or my power of attorney. I understand that it is ultimately my responsibility to notify the TPA if my premium amount changes. I hereby agree to hold my employer, the TPA, and the Montana VEBA HRA Plan harmless for any damages that may occur from following the instructions on this form. I hereby certify that the foregoing statements are true and correct and the premium amount submitted is the accurate amount of my cost of qualified insurance premiums.

This paragraph applies only if you completed Section 3 above: I hereby authorize and request the TPA to electronically deposit a monthly reimbursement for my insurance premiums to the financial institution designated above. This authorization is not an assignment of my rights to receive payment and revokes all prior payment direction notifications. I understand this authorization will remain in effect until my account is depleted or cancelled by written notice from me or my power of attorney.

Required documentation attached? ☐ **Yes** ☐ **No**

X_____ _____

Participant Signature Date

IMPORTANT REMINDERS

1. Approximately three (3) months before your account is expected to run out, any portion of your remaining account balance not already allocated to your plan's default investment fund will be transferred to protect your account against losses in case significant negative market changes occur. Notification will be sent to you.
2. Don't forget to attach the required documentation as described in section 2 on reverse.
3. **When your premium amount(s) change, it is your responsibility to notify the third-party administrator (TPA) to adjust your systematic premium reimbursement amount.**
4. Please use your participant account number or Social Security number when communicating with the TPA.
5. Be sure to notify the TPA if your mailing address changes.
6. Long-term care premium reimbursements must be for tax-qualified long-term care coverage and are subject to annual IRS limits.

Questions? Contact the third-party administrator, Rehn & Associates, at montana@rehnonline.com or 1-800-832-2101