Recurring Premium Reimbursement Claim Form

ExtendHealth®

Mail to: Extend Health
P.O. Box 2396
Omaha, NE 68103-2396

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855-321-2605
Page 1 of

① Account Holder - Last Name | First Name | MI

Social Security Number | Zip Code

② Covered Participant - Last Name | First Name | MI

Social Security Number | Relation to Account Holder (e.g., self, spouse)

③ New/Change/End	Premium Type	Start Date	End Date	Monthly Amount

④ Certification

By signing below, I certify that the information provided on this claim form is correct and that the expenses for which I am requesting reimbursement or for which I am providing validation: were incurred for premiums for me or my eligible dependent under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. Upon receiving notice of a change in premium or the cancellation of a policy, I will notify Extend Health of the change as soon as possible.

Account Holder Signature | Date

⑤ Claim Documentation

Your claim will not be paid without your supporting documents submitted with this claim form. See the documentation instructions on the reverse side of this form for more information.

Guide to Requesting Recurring Premium Reimbursement

The attached form allows you to request recurring reimbursements of your health care premiums.

■ Recurring premiums may include Medicare supplement plans (Medigap), Medicare Part B (SSA premiums), Medicare Part C (Medicare Advantage), or Medicare Part D (prescription drug).

① **Account Holder Information –** The account holder is usually the retiree or the surviving spouse.

② **Covered Participant Information –** This is the person requesting the reimbursement for their premiums. Include the relationship to the account holder.

③ **Reimbursement Request Information –** This section must be filled out for the covered participant requesting the reimbursement. You must complete a separate form for each covered participant.

New Policy/Premium Change/End of Policy – A claim form must be filed each time you have a new policy, the first of a new year, a change in your premium, or if a policy ends for any reason during the calendar year.

Type of Premium – Enter the type of premium (e.g., medical, Rx). Your Summary Plan Description will give you specific details on the types of premiums that can be submitted.

Start Date – This is usually January 1st but can be later, depending on when the covered participant is Medicare-eligible or the effective date of the coverage period.

End Date – This is usually December 31st but could be earlier for a policy change or the death of a covered participant.

Monthly Amount – Monthly amount you are requesting must match the amount on the supporting document.

④ **Certification Requirement –** Carefully read the certification requirements before signing.

⑤ **Documenting Your Premium Claims –** All premium claims require a third party document showing the coverage information.

Claims cannot be approved without the correct documentation being provided.

■ For Health premium claims (e.g., medical, Rx) you must have documentations including:

- Covered participant's name (John Doe)
- Name of the provider (AARP)
- Date of coverage (January to December)
- Description of coverage (Medigap)
- Premium amount (e.g. $122.55)

If you have lost a document, contact your coverage provider to request a copy.

■ For Medicare premiums deducted from your Social Security check, provide your "Proof of Income Letter" from the Social Security Administration, sometimes called a budget, benefits, or proof of award letter.

For lost letters, you can request a Proof of Income Letter by contacting the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) or www.ssa.gov.

Recurring claims must be re-submitted each calendar year in order to continue the recurring reimbursement.