44640

RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST FORM

TASC

Submit this completed form via online Support Request, fax, or mail:	Online or Mobile App	Fax	Mail
	Sign into your Universal Benefit Account and submit with your online Reimbursement Request or via a Support Request (click Contact Us)	(608) 661-9601	TASC, PO Box 7308 Madison, WI 53704-7308

Employer Tasc ID Number 4320-5109-3022 **Employer Name:** Evansville Vanderburgh School Corp.
(Former Employer for Retirees)

Plan Year: _____

From what initial date would you like reimbursements of your premium(s) to start? _____

INDIVIDUAL/PARTICIPANT/RETIREE INFORMATION

First Name:_____ **MI:**_____ **Last Name:**_____

TASC ID#(if known):_____ **E-Mail Address:**_____

Primary Phone#:_____ **Mobile Phone#:**_____

Primary Address(cannot be PO Box)

Address Line 1:_____ **Address Line 2:**_____

City:_____ **State:**_____ **Zip Code:**_____ **+4**_____

INDIVIDUAL POLICY INFORMATION

This is required information and must be filled out completely to process your request.

Name of Insured Person:_____

Name of Insurance Carrier:_____

Type of Coverage_____

Plan Year/Policy Start Date:_____ **Plan Year/Policy End Date*:**_____

Total Monthly Premium Amount Requested: $_____

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EMPLOYEE ACKNOWLEDGEMENT OF RECURRING PREMIUM REIMBURSEMENT REQUEST

Please initial next to each line to indicate you acknowledge the terms of this recurring premium reimbursement request.

_____ I understand that insurance premiums are considered to be incurred on the first day of the month of coverage and that I cannot be reimbursed for expenses prior to that, regardless of the date the insurance bill was paid.

_____ I have attached a proof of my insurance coverage that includes the type of coverage, premium amount, and contract period. Acceptable documents include a letter from the insurance company that includes the above information, a copy of a contract renewal letter, or a letter from the former employer sponsoring the plan.

_____ I understand that I will be set up for recurring reimbursement until the plan year/policy end date, when the rates will most likely change. I understand that I will need to complete a new form and send proof of insurance coverage when my insurance premiums change at the end of the plan year/contract or for any other reason.

_____I understand that I am required to have direct deposit set up with TASC to receive reimbursements.

_____In the event that my coverage is terminated for any reason, I am required to inform TASC within five (5) days of the termination so that future reimbursements can be stopped.

_____ I certify the above information is correct and the expenses claimed will incur on a regular basis by me or my eligible dependents after my effective date of coverage in my employer's benefit plan. I certify these expenses are not eligible for reimbursement under any other plan and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return and I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

AUTHORIZATION

I certify the recurring expenses and claims for reimbursement.

_____ _____

Authorized Signature **Date**

_____

Please Print Name of Signature

_____

Title