Recurring Individual Premium Reimbursement Request Form

Submit this completed form via fax or mail:	Fax	Mail
	269-327-0716	BASIC, PO Box 6278 Monona, WI 53716

(Former) Employer Name:	
Employer ID #	
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:	
Individual ID# (if known):		Email Address:			
Primary Phone #:		Mobile Phone #:			
Primary Address: *(cannot be PO Box)*	Address 1:			Apt:	
	Address 2:				
	City:				
	State:		ZIP Code:	+4:	
Retirement Date:		Social Security Number:			

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 Individual Premium Amount Requested:		$	

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 BASIC to receive reimbursements.

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_____ In the event that my coverage is terminated for any reason, I am required to inform BASIC 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