

# Systematic Premium Reimbursement Form

Montana VEBA HRA Third-Party Administrator – Rehn & Associates  
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## Personal Information

Last Name		First Name		Participant Account No. or SSN	
Mailing Address		<input type="checkbox"/> Check here if new	City	State	Zip
Email Address		<input type="checkbox"/> Check here if new	( )	Phone Number	

## Systematic Premiums Reimbursement Instructions

You must attach documentation which includes the following: (1) name of covered individuals; (2) premium amount; (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  Check this box if you wish to receive reimbursement retroactive to this date

**Date first reimbursement should be received:** \_\_\_\_\_

**Effective date of insurance coverage change:** \_\_\_\_\_

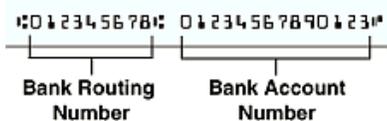
**Amount of Reimbursement:** \_\_\_\_\_

**Frequency (check one):**  Monthly  Quarterly  Semi-Annually  Annually

**Is policy in your name?**  Yes  No\*

\* If no, please list the name and SSN of the policy holder: \_\_\_\_\_

## Direct Deposit Information



**Account:**  Checking  Savings

**Financial Institution:** \_\_\_\_\_

**Routing Number:** \_\_\_\_\_

**Account Number:** \_\_\_\_\_

## Authorized 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 fore-going 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 the direct deposit section 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.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

## IMPORTANT REMINDERS:

- Attach the required documentation as described above
- It is your responsibility to keep the TPA updated if your premium amount changes
- Please include your Account Number or SSN when communicating with the TPA
- Long-term care premium reimbursements must be for tax-qualified long-term care coverage and is subject to annual IRS limits.