Auto Premium Reimbursement

Skip this form! Log in at **hraveba.org** and submit your request online.
Important reminders and information on reverse.

HV02

SUBMIT COMPLETED FORM TO:
claims@hraveba.org | Fax: (206) 577-3020 | HRA VEBA Plan, PO Box 80587, Seattle, WA 98108

Actively-employed participants receiving monthly employer contributions must have a minimum account balance of $2,000 to begin/renew an auto premium reimbursement.

1 PARTICIPANT ACCOUNT AND CONTACT INFORMATION

If you are claims-eligible under more than one participant account, enter the participant account number of the account from which you want your auto reimbursement. Otherwise, your auto reimbursement will be taken from the account with the earliest claims-eligibility date. **All information in this section is required to process your auto premium reimbursement request.**

ACCOUNT NUMBER or SSN _____ DATE OF BIRTH MM / DD / YYYY _____

LAST NAME _____

FIRST NAME _____ M.I. _____

HAVE YOU PREVIOUSLY SEPARATED OR RETIRED FROM THE EMPLOYER THAT MADE/IS MAKING CONTRIBUTIONS TO THIS ACCOUNT?

☐ YES DATE OF SEPARATION OR RETIREMENT MM / DD / YYYY _____
☐ NO

EMPLOYER NAME _____

☐ **CHECK HERE IF YOUR PHONE NUMBER, EMAIL, OR MAILING ADDRESS HAS CHANGED. PLEASE PROVIDE UPDATES BELOW:**

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS IS REQUIRED (use home or personal email address) _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

☐ **E-COMMUNICATION:**

Please check the box above and enter your email address at the left to sign-up for e-communication. Read details on reverse.

2 AUTO PREMIUM REIMBURSEMENT INFORMATION

You MUST attach documentation that includes: (1) name(s) of covered individuals or policy holder; (2) premium amounts(s); (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. If required documentation is not received, your auto premium reimbursement request will be denied. **Premiums paid by an employer, deducted pre-tax through a Section 125 cafeteria plan or subsidized by the Premium Tax Credit are not eligible for reimbursement.** If this reimbursement request is for long-term care insurance premiums, you must include a copy of the policy's Declaration page to confirm that the policy is tax-qualified.

THIS IS A: ☐ **NEW** request
☐ **CHANGE** to current reimbursement

AMOUNT OF EACH REIMBURSEMENT:

NEW AMOUNT $ _____

OLD AMOUNT (if this is a change) $ _____

FREQUENCY: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Beginning with coverage for month/year of: _____ MM / YYYY

DUE DATE OF FIRST REIMBURSEMENT: (To occur on time, request must be received at least 10 days prior to due date)

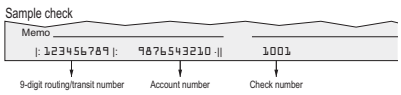
☐ 1st or ☐ 15th day of the month

☐ Please make my first reimbursement retroactive to my requested due date, if this date is in the past, or if this request is not received in time.

3 DIRECT DEPOSIT ENROLLMENT (RECOMMENDED)

Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. Information you provide below will supersede any previous direct deposit enrollment on file. A voided check is not required.

☐ **USE DIRECT DEPOSIT ALREADY ON FILE**



ACCOUNT TYPE:

☐ Checking
☐ Savings

NAME OF FINANCIAL INSTITUTION (bank or credit union) _____

9-DIGIT ROUTING NUMBER (see sample check) _____ ACCOUNT NUMBER (do not include check number) _____

4 REQUIRED PARTICIPANT SIGNATURE AND AUTHORIZATION

I (participant) hereby authorize the Plan to disburse funds from my participant account as provided for in this form. I understand that approximately three (3) months before my account is expected to run out, any portion of my remaining account balance not already allocated to Stable Value will be transferred to protect my account against losses in case significant negative market changes occur. I hereby agree to hold my employer, the HRA VEBA Trustees, the HRA VEBA plan, and it's service providers harmless for any damages that may occur from following the instructions on this form. I hereby certify that (1) the foregoing statements are true and correct, (2) the premium amount submitted is the accurate amount of my cost of qualified insurance premiums, and (3) all such persons covered under the insurance policy are qualified dependents under the terms of the Plan, and (4) premiums for which I am requesting reimbursement are not being paid by an employer and are not eligible for pre-tax deduction through my employer's section 125 cafeteria plan. I acknowledge and agree that any claim submitted fraudulently could result in my termination from the Plan and/or other legal action. I understand that it is my responsibility to notify the Plan if my premium amount or other information changes. For direct deposits: I hereby authorize and request the Plan to electronically deposit a periodic reimbursement for my insurance premium(s) to the financial institution designated above or already on file with the Plan. This authorization is not an assignment of my right to receive payment and revokes all prior payment direction notifications. I understand funds availability is subject to my banking institution's policies and procedures. I understand the authorization(s) on this form will remain in effect with HRA VEBA until my account is depleted or until cancelled by written notice from me or my power of attorney.

REQUIRED DOCUMENTATION ATTACHED? ☐ **YES** ☐ **NO**

X _____ DATE MM / DD / YYYY _____ PHONE NUMBER WHERE I CAN BE REACHED _____

PARTICIPANT SIGNATURE

QUESTIONS? 1-888-659-8828 | customercare@hraveba.org | hraveba.org

Important reminders on reverse ▶

For new auto premium reimbursements

Step 1: Be sure to attach the required documentation as described in section 2 when submitting this form.

Step 2: Long-term care premium reimbursements must be for tax-qualified long-term care coverage and are subject to annual IRS limits. You must include a copy of your policy's Declarations page to confirm that the policy is tax-qualified.

After initial set-up

- When your premium amount(s) change, or if you are no longer paying the premium, it is your responsibility to notify us to adjust your auto premium reimbursement amount. Failure to update this information may result in your reimbursement no longer being a valid reimbursement exempt from taxation. Changes must be received 10 calendar days prior to due date.
- Be sure to notify us if your mailing address changes.
- Approximately three (3) months before your account is expected to run out, any portion of your remaining account balance not already allocated to Stable Value will be transferred to protect your account against losses in case significant negative market changes occur. Notification will be sent to you. The Stable Value fund is HRA VEBA's most conservative investment.

Qualified PEBB retiree insurance premiums

Qualified PEBB retiree insurance premiums include amounts paid for medical, dental, Medicare Advantage, and Medicare supplement plans.

Step 1: Authorize the Department of Retirement Systems (DRS) to deduct from your retirement allowance the amount you are required to pay for qualified insurance coverage. You can authorize this deduction on your PEBB enrollment form, or you can mail written authorization to: Washington State Health Care Authority, PO Box 42684, Olympia, WA 98504-2684.

Step 2: Set up an auto premium reimbursement from your HRA VEBA account by submitting a completed and signed **Auto Premium Reimbursement** form to HRA VEBA. Use the mailing address or fax number appearing on the front side of this form. Reimbursements can be direct deposited to your designated bank account (recommended; see section 3).

E-communication

E-communication is fast and convenient. E-communication provides email notification as soon as your participant account statements and explanations of benefits (EOBs) are available online. You will also receive newsletters, important notices, and general information via email.

If you have elected e-communication on the front of this form, please note that after logging in to your account at **hraveba.org**, you (1) may withdraw your consent for electronic documents at any time without charge by updating your account preferences; (2) will be able to view and print copies of electronic documents (you may request paper copies at no charge by contacting HRA VEBA's customer care center); and (3) can update your email address on file by updating your personal information. To access electronic documents, you will need a copy of Adobe Acrobat Reader software loaded on your computer. You can download and install a free copy at www.adobe.com. Documents provided electronically will not be mailed via U.S. Mail.