

# Systematic Premium Reimbursement Form

Skip this form! Go paperless at [hraveba.org](http://hraveba.org). Click **myHRA VEBA Plan online** to login to your account.  
Or, e-mail, fax, or mail completed form to third-party administrator. Instructions on reverse. Fillable version at [hraveba.org](http://hraveba.org).



## HRA VEBA Third-party Administrator

Meritain Health | PO Box 27810 | Minneapolis, MN 55427-0810  
Phone: 1-888-659-8828 | Claim Fax: (763) 582-3470 | E-mail: [myclaims@meritain.com](mailto:myclaims@meritain.com)

**NOTE:** Actively employed participants receiving monthly employer contributions must have a minimum participant account balance of \$2,000 to begin/renew a systematic premium reimbursement.

### 1. PARTICIPANT INFORMATION

Last Name	First Name	Participant Account No. or SSN
E-mail Address (home or personal recommended) <input type="checkbox"/> Check here if new e-mail address		( ) - Area Code and Phone Number
Mailing Address <input type="checkbox"/> Check here if new address	City	State Zip

### 2. DIRECT DEPOSIT ENROLLMENT (recommended)

If you are not already enrolled in direct deposit, systematic premium reimbursement will be mailed to you via paper check. Information you provide below will supersede any previous direct deposit enrollment on file. When requesting direct deposit to a **checking account**, a voided check must be attached for routing and account number verification. For direct deposit to a **savings account**, please contact your financial institution for routing and account number verification if a voided check is not available. Funds availability is subject to your banking institution's policies and procedures.

Account type [check one]:

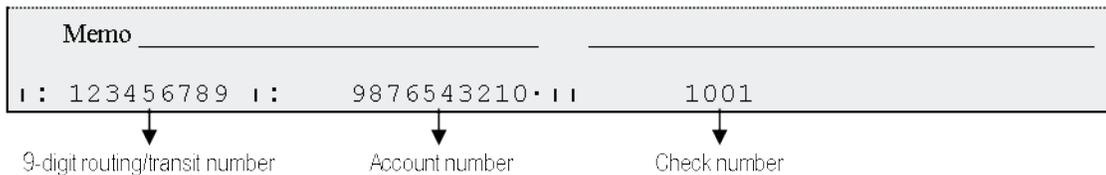
- Checking account
- Savings account

Name of financial institution (bank or credit union)

9-digit routing/transit number (see sample check below)

Account number (do not include your check number)

#### Sample check



### 3. SYSTEMATIC PREMIUM REIMBURSEMENT INFORMATION

You must attach documentation which includes the following: (1) name(s) of covered individual(s); (2) premium amount(s); (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 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 **NOTE:** Please submit changes at least **10 calendar days** prior to due date.

Effective date of coverage or change: ____/____/____ Month Day Year	Date first reimbursement should be received: ____/____/____ Month Day Year
Amount of each reimbursement: \$ _____	Frequency [check one]: <input type="checkbox"/> Monthly (once a month) <input type="checkbox"/> Semi-annually (once every six months) <input type="checkbox"/> Quarterly (every three months) <input type="checkbox"/> Annually (once a year)

### 4. AUTHORIZING 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 with HRA VEBA Trust until my account is depleted or cancelled by written notice from me or my power of attorney. 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 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 HRA VEBA Trustees harmless for any damages that may occur from following the instructions on this form. I hereby certify that the foregoing statements are true and correct and the premium amount submitted is the accurate amount of my cost of qualified insurance premiums.

For direct deposits: I hereby authorize and request the TPA to electronically deposit a monthly reimbursement for my insurance premium(s) to the financial institution designated above or already on file with the TPA. This authorization is not an assignment of my right to receive payment and revokes all prior payment direction notifications. I understand this authorization will remain in effect with HRA VEBA Trust until my account is depleted or cancelled by written notice from me or my power of attorney.

Required documentation attached?  Yes  No

X \_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

## IMPORTANT REMINDERS

1. 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 Trust's most conservative investment.
2. Don't forget to attach the required documentation as described in section 3 on reverse.
3. **When your premium amount(s) change, it is your responsibility to notify the third-party administrator (TPA) to adjust your systematic premium reimbursement amount. Please submit changes at least 10 calendar days prior to due date.**
4. Please use your participant account number or Social Security number when communicating with the TPA.
5. Be sure to notify the TPA if your mailing address changes.
6. Long-term care premium reimbursements must be for tax-qualified long-term care coverage and are subject to annual IRS limits.

**Questions?** Contact the third-party administrator, Meritain Health, at [myHRAVEBA@meritain.com](mailto:myHRAVEBA@meritain.com) or **1-888-659-8828**.