# Monthly Recurring Insurance Premium Reimbursement Request Form

**Instructions**

1. Complete all sections of this form. **PLEASE NOTE:** Only use this form for **insurance premium reimbursement** requests **(including Medicare premiums)**.
2. Please attach appropriate documentation (list found on page 2) to set up the filing of your insurance premium claim reimbursement.
3. Securely email, mail, or fax completed form and copies of the necessary documentation to:

   **Secure Email:** Fidelity@service.healthaccountservices.com**,** **Fax:** (855) 810-8223,

   **Address:** Fidelity Flexible Spending and Reimbursement Accounts Services, PO Box 2703, Fargo, ND 58108-2703
4. If you have any questions about completing this form, please contact Fidelity Flexible Spending and Reimbursement Accounts Services Consumer Services at (800) 354-3412. We have representatives available Monday-Friday, 7:30 am – 7 pm CT.

**Step 1: Consumer Information**

*Required Fields

*Consumer Name (First, MI, Last)

*Employer Name

*Birth Date (MM/DD/YYYY) / /

*Social Security Number - -

*Phone Number ( ) -

*Permanent Address

Email Address

*City

*State

*Zip Code

**Step 2: Coverage Information and Verification of Expenses**

*Please only choose one option.

Please Note: Claims cannot be approved without the necessary documentation. Please see page 2 for a list of these required items-

**Option 1: File a One Time Claim**

*Issue reimbursement of expense for specific claim details provided below.*

*Effective Date (MM/DD/YYYY)

*Type of Coverage

*Insurance Carrier Name

*Total Premium Amount

**Option 2: File a Recurring Claim**

*Select Start, Change, or Stop Auto Reimbursement of expense for specific claim details provided below.*

| | |
|---|---|
| | **Start Auto Reimbursement**: begin automatic reimbursement of my expenses effective by the date specified above |
| | **Change Auto Reimbursement**: update my automatic reimbursement information with the provided information effective by the date specified below |
| | **Stop Auto Reimbursement**: stop automatic reimbursement of my effective by the date specified above |

*Effective Date (MM/DD/YYYY)

*Type of Coverage

*Insurance Carrier Name

*Monthly Premium Amount

**Step 3: Consumer Certification**

To the best of my knowledge the provided information is complete and accurate. I verify that I pay no less than the above amount for the attached expenses(s) submitted to my account with Fidelity Flexible Spending and Reimbursement Accounts Services. I understand that my submission of this form is to be reimbursed for the specified expense(s). I certify that the requests I am submitting are eligible expenses for an eligible individual as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Fidelity Reimbursement Accounts Services, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. If there are any changes in the provided information. I understand it is my responsibility to notify Fidelity Flexible Spending and Reimbursement Accounts Services. I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature

*Date

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**PLEASE NOTE:** Upon successful submission of this claim, should you choose automatic reimbursement you will receive a confirmation each time the claim is automatically filed on your behalf. **If any information on this request changes during the plan year, you must submit an updated form.**

## Tips for Form Completion

This form provides the option for automatic reimbursement of insurance premiums. Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

**Reimbursement Information**

- **Effective Date**: Date of this claim
- **Total Premium Amount (One-time Reimbursement) / Monthly Premium Amount (Recurring Reimbursement)**: Total dollar amount you are requesting to be reimbursed
- **Insurance Carrier Name**: Name of insurance company
- **Type of insurance coverage**: Medical, Dental, Vision, etc.
- **If you choose Option 2 (Automatic Payment to your carrier) make sure you stop the automatic payment to the previous carrier**!

## Documentation Requirements

Important: To receive reimbursements, you must supply the required documents outlined below along with this completed claim form.

*One-time* reimbursement requests require that substantiation documentation be provided with each request.

*Recurring* reimbursements require substantiation documentation annually. Note that auto-recurring reimbursements will automatically stop at the end of the calendar year. A new Recurring Reimbursement Request form, along with documentation, must be submitted annually.

**Proof of Coverage:** Before you can be reimbursed, you must provide documentation (coupon slips, itemized statement or letter from insurance company) that includes the following:

**Insurance Premiums**

- Name(s) of covered individuals
- Insurance company name
- Dates of coverage
- Type of coverage
- Premium amount

**Medicare Premiums**

- If your Medicare Premiums are deducted from your Social Security check, include your Social Security Administration (SSA) award letter that includes the Medicare premium amount.
- If you pay your Medicare premium directly to Medicare, include your billing statement from Centers for Medicare and Medicaid Services (CMS).