Retiree Health Insurance Reimbursement Form

Mail: P.O. Box ???? Bedford, MA 01730 **Email:** administrator@edcollab.org

To avoid delay in processing your reimbursement, please print clearly and be sure to include all supporting documents.

① Retiree's SSN

Insurance Provider (Tufts, BlueCross, Harvard ect)

Total Pages

Last Name of Insured

First Name of Insured

Email Address

Daytime Phone Number

② Month of Coverage MM/YYYY | Type of Coverage | Covered Participant Name | Relationship | Amount Requested

07/2021	*Medical*	*John Doe*	*Retiree/Spouse*	*$XXX.XX*

③ By signing below, I certify that the information provided on this reimbursement form is correct and that the premiums for which I am requesting or for which I am providing validation: were incurred for premiums for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement.

Signature

Date

④ To qualify for your reimbursement you must provide a third party document that includes the information to the right. Please CHECK ☑ Each Reimbursement Qualification item as you complete them.

☑ Does your document(s) include these items?

- ☐ Covered Participant Name (e.g. John Doe)
- ☐ Provider Name (e.g. AARP)
- ☐ Date of Service (e.g. 01/01/20XX)
- ☐ Description of Coverage (e.g. Tufts)
- ☐ Proof of Payment

Guide to Requesting Reimbursement

To request reimbursement for your health care premiums use this form.

1.) Reimbursement Information:

Complete this section to indicate the Date of Service; Type of Coverage (e.g. Medicare, Dental;) Covered Participant Name and Relationship to the retiree and Amount Requested, which should be the entire expense you incurred/paid.

2.) Certification Requirements:

Carefully read the certification requirements before signing.

3.) Individual Reporting

If you are requesting reimbursement for yourself AND a spouse, please be sure to note each individual separately in section 2.

4.) Premium Reimbursement

Supporting Documentation:

To file a request for a health premium you must provide supporting document(s) from a third party insurance provider (*e.g. Tufts, BlueCross, Harvard*) to certify the request.

A premium statement AND a bank statement, or a canceled check or premium statement showing the amount paid, should include all of the required information.

The payment amount must match the amount on the premium statement. When submitting a request for your premium reimbursement, the coverage period start date should be used as the date of service, not the date of payment.

Requests for future premiums can be submitted with this form as long as the future premiums have been paid.

Documents and Reimbursement

Submission – Reimbursements cannot be processed without the required information or documents. If you have lost a document, contact your health insurance carrier to request a copy.

Reimbursement requests can be submitted via email or our mailing address.

Payment will be mailed to the address you provided on the front of this form.

Please allow 4 - 6 weeks for processing of your reimbursement.