State of Indiana Retirement Medical Benefits Account Plan Claim Form

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THIS FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Retiree Name: _____ Retiree SSN: - -

Email address: _____

Home Address: _____
Number & Street City State Zip Code

Daytime Phone Number: _____ Number of pages: _____

☐ Please check if new address, email or phone number

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for Qualified Premium Expenses incurred by me, my spouse, or my Covered Dependent(s) during the applicable plan year. I certify that these expenses have not been reimbursed by any other source, are not pre-taxed under a Section 125 Flexible Benefits Plan, nor will any reimbursement be sought from any other source. I authorize my ***Retirement Medical Benefits*** *Account Plan be reduced by the amount requested.*

Employee Signature: _____ Date: _____
Signature Required

Insurance Premium Expenses*:*
Insurance Premium receipts or statements must be from an independent third-party and must include the Name of the Retiree, Spouse or Covered Dependent, Name of the Provider, Type of Insurance, the month(s) covered and the Amount of the Insurance Premium. Proof of payment is also required. If necessary, please add additional pages.

Name of Retiree or Covered Dependent	Month(s) Covered	Name of Provider (i.e., Anthem)	Type of Insurance	Amount of Premium
			Total:	

The following reimbursement request rules apply: Insurance expenses must be incurred within the appropriate retiree eligibility period. Photocopies are acceptable. Please retain a copy of all claims for your own records. *Cancelled checks are only acceptable as proof of payment not as receipts*. This form must be signed and submitted with the applicable information.

NOTE: In the event of a bank deposit rejection because the retiree fails to advise KBA of a change in the banking account utilized for direct deposits, a fee of $30.00 may be assessed.

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