Gallagher | HealthInvest HRA

In partnership with EMPOWER

HI01 5/25 PRC

Automatic Premium Reimbursement Form

If you have separated or retired from the County of Orange, use this form to set up a recurring reimbursement for your eligible insurance premiums.

Submit your claims and supporting documentation online. It's faster and more secure.

(1) Log in at **HRAgo®** (mobile app) or **CountyofOrange.HealthInvestHRA.com**; (2) Click **Claims**; and (3) Click **Set Up an Automatic Premium Reimbursement**. Or, mail completed form and supporting documentation to: HealthInvest HRA, PO Box 4390, Clinton, IA 52733-4390.

Make sure your documentation has everything we need!

The documentation you submit needs to contain all four of the following:

1. Name of covered individual(s);
2. Coverage period or effective date;
3. Name of insurance carrier; and
4. Premium amount.

Common forms of documentation include your statement of insurance, open enrollment notice, or premium billing statement. **If you are requesting reimbursement for tax-qualified long-term care insurance premiums**, be sure to include a copy of your policy's Declarations page. The Declarations page usually contains confirmation that the policy is tax-qualified.

Is my premium eligible?

The below list of qualified premiums is not a complete list, but it does contain many examples of the types of premiums eligible for reimbursement.

- Medical*
- Dental
- Vision
- Long-term care (tax-qualified; subject to IRS limits)
- Medicare
- Medicare supplement plans
- TRICARE premiums (medical and dental plans)

* *Includes marketplace exchange premiums that **are not or will not be** subsidized by the premium tax credit.*

As a reminder, premiums are not eligible for reimbursement if they are:

1. Paid by an employer;
2. Deducted pre-tax through a Section 125 cafeteria plan;
3. Eligible for pre-tax deduction from your (the participant's) paycheck through your employer's Section 125 cafeteria plan; or
4. Subsidized by the premium tax credit.

What should I do next?

- When your premium amount(s) change or stop, it is your responsibility to notify us to adjust or cancel your automatic premium reimbursement. Failure to update this information may result in your reimbursement(s) being cancelled and/or excess reimbursement amounts being reported as taxable income.
- Be sure to notify us if your direct deposit information or mailing address changes.

Complete Automatic Premium Reimbursement form on reverse ▶▶

Questions? 1-833-382-2617

Login Online CountyofOrange.HealthInvestHRA.com

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1 PARTICIPANT INFORMATION

All information in this section is required to process your automatic premium reimbursement request.

ACCOUNT NUMBER or SSN _____ DATE OF BIRTH mm / dd / yyyy _____

LAST NAME _____ FIRST NAME _____ M.I. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

2 CERTIFICATIONS: READ BEFORE SUBMITTING

By completing and submitting this form, you agree to the **Terms and Conditions**, as amended from time to time, which can be found in the **Summary Plan Description**. To get a current copy, log in at **CountyofOrange.HealthInvestHRA.com** and click **Resources**.

The following certification applies only to major medical premiums. It does not apply to dental, vision, and tax-qualified long-term care premiums: Any major medical premium was **either** (a) for an employer-sponsored group health plan (for coverage provided through an employer) and not for individual market coverage, **or** (2) incurred while you were separated or retired (not employed or re-employed) from County of Orange.

3 AUTOMATIC PREMIUM REIMBURSEMENT INFORMATION

This is a: ☐ **NEW** request ☐ **CHANGE** to existing reimbursement

Amount of each reimbursement:

NEW AMOUNT $ _____

OLD AMOUNT *(If this is a change)* $ _____

Frequency: ☐ Monthly ☐ Quarterly

BEGIN mm / yyyy: _____

This APR will remain in effect for 12 months or through the end of your current policy period, whichever occurs first. We'll notify you when it's time to renew your APR and submit updated documentation.

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 the due date is in the past, or if this request is not received in time.

Is the policy in your name?

☐ YES
☐ NO

If reimbursement is for a policy not in your name (such as your spouse's), please list his/her name, Social Security number or policy number, and date of birth.

NAME _____ SSN or POLICY NUMBER _____ DATE OF BIRTH _____

4 DIRECT DEPOSIT ENROLLMENT (RECOMMENDED)

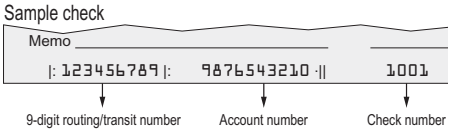
Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. Information you provide below will supersede any previous direct deposit enrollment on file. A voided check is not required.

☐ New request

☐ Use direct deposit already on file

NAME OF BANK OR CREDIT UNION _____ ☐ Checking ☐ Savings

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



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