Mercer Marketplace 365+℠

RECURRING PREMIUM REIMBURSEMENT CLAIM FORM

Complete this form to request reimbursement of your eligible premiums. Refer to the back page for instructions on how to complete the information below. Please print legibly in blue or black ink. **NOTE: Do not complete this form if you have signed up for Automatic Premium Reimbursement.**

☐ **All premium reimbursement requests require third-party documentation – use the checklist on the back page to see what information is required. Please CHECK ☑ each box to ensure you provide complete information and sign the bottom of the form before you send to Mercer.**

☐ Account Holder SSN (last 4 digits only):

Former Employer Name:

Total Pages Included:

Account Holder Last Name:

Account Holder First Name:

Email Address:

Daytime Phone Number (No Dashes):

☐

Name and Relationship to the Account Holder	Premium Type	Start Date	End Date	Expense Amount	Amount Requested*
John Doe – Self	Medical	01/01/20XX	12/31/20XX	$200.00	$200.00
Jane Doe – Spouse	Medical	01/01/20XX	12/31/20XX	$175.00	$125.00

☐ **PARTICIPANT CERTIFICATION** I have read this document and understand and confirm that as a Participant in the Plan, premiums itemized above for myself and any eligible dependents will be deducted from my subsidy Account and reimbursed to me directly every month beginning _____ (date). I understand the Plan will reimburse me based on the expenses I submit provided there are sufficient funds in my subsidy Account. I understand it is my sole responsibility to inform the Plan administrator if my coverage ends or my monthly premium amount changes from the amount shown above. I accept full liability for timely notification of any changes. I, the undersigned, certify that all expenses for which reimbursement is requested by submission of this form were incurred by myself or an eligible dependent and that the expenses have not been reimbursed, or are not reimbursable, from any other source. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, is compliant with the plan rules set forth by my former employer, and that if an expense for which payment or reimbursement is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense.

ACCOUNT HOLDER SIGNATURE **DATE**

REMINDER – IT IS FASTER AND EASIER TO SUBMIT YOUR CLAIM ONLINE. IF YOU PREFER TO SUBMIT A PAPER FORM, FOLLOW THE DIRECTIONS BELOW.

USE THIS FORM to request reimbursement of your eligible healthcare premiums. Do not submit this form if you have signed up for Automatic Premium Reimbursement. Refer to the online portal for more information on reimbursement options.

Your request, if approved, provides ongoing monthly reimbursements for premiums for the calendar year.

- Annual submission is required each year even if your plan does not change. If submission occurs after the start of the year, previous months will be paid retroactively.
- **Please note:** Your first premium reimbursement may take 4 to 6 weeks to arrive.

☐ **Step 1 – Complete the form** – In the grey area, complete a separate line for each premium expense.

☐ **Step 2 - Provide the insurance carrier documentation showing each item below:**

- ☐ Covered Participant's Name (e.g. John Doe)
- ☐ Premium Type (e.g. Medical)
- ☐ Coverage period (e.g. 01/01/20XX–12/31/20XX)
- ☐ Premium amount (e.g. $XXX.XX)
- ☐ Name of Insurance Carrier (e.g. AARP)

☐ **Step 3 - Certification Requirement:**
Carefully read the certification requirements before signing. **Your reimbursement request cannot be processed without the signature of the account holder**

Important Information:

Third-party documentation is often provided in the Annual Notice of Change letter or a billing coupon from your insurance carrier. All information must be included in your documentation.

For Medicare premiums deducted from your Social Security check, use the Social Security Benefit Award Letter issued by the Social Security Administration (SSA) each year, as your third party documentation. **Watch for this document to arrive in the mail.**

☐ **Account Holder Information:**
The account holder is determined by your plan rules. If you have a Household account, the primary account holder must sign; if you have an Individual account, the individual account holder must sign his or her own form. Please refer to the letter you received from Mercer Marketplace 365+ Retiree to understand if you have a Household or Individual account. Call Mercer if you have questions about your account type.

Relationship: Include the relationship between the account holder and the person requesting the premium reimbursement (e.g. self).

Premium Type: Refer to your Reimbursement Instructional Guide (e.g. Medical, Prescription Drug).

Start and End Date: This is usually January 1st of each new year or the effective date of the coverage period which typically ends December 31st. This could differ if you have a change in your current plan or premium, a change in reporting by your carrier, or the death of a covered participant.

Amount Requested: This is the amount you are requesting to be reimbursed. This must not exceed the amount of the premium that is noted on the supporting document. If you request an amount higher than your account balance, any amount not reimbursed will be pended and reimbursed in a future reimbursement. You may request an amount that is less than the total premium or expense.

Direct Deposit:
Expedite your payments by signing up for direct deposit. Refer to your Reimbursement Guide for instructions on how to log into the portal and complete the necessary steps to receive your reimbursements by direct deposit.

Submit the completed claim form through one of the following methods:

Mail: Mercer Health & Benefits Admin.,
P.O. Box 14401, Attn: Claims Department
Des Moines, IA 50306-3401

Fax: 1-857-362-2999, Attn: Claims Department

Please include the participant's name in all correspondence, regardless of submission method. If mailing, retain all originals and only mail copies.