Mercer Marketplace 365+SM

RECURRING PREMIUM REIMBURSEMENT CLAIM FORM

Use this form for reimbursement of eligible premiums for qualifying plans. Refer to the back page of this form 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.**

☐ To qualify for your reimbursement, you must provide third-party documentation that includes the information on the back of this form. **Please CHECK ☑ each reimbursement request qualification item as you complete it, 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

*Mercer will process your claim for the amount requested, available in your subsidy account, and eligible to receive.

☐ **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**

RECURRING PREMIUM REIMBURSEMENT CLAIM FORM

USE THIS FORM for reimbursement of eligible healthcare premiums for qualifying plans. 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.

Remember, for a faster, more convenient method, **submit online**, using the website shown in your Reimbursement Instructional Guide. Alternately, you may 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.

Submitting this form 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.

☐ **Documenting Your Reimbursement Request — All premium reimbursement requests require third-party documentation showing each item below:**

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

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, typically during the month of October or November, as your third party documentation. **Watch for this document to arrive in the mail.**

For lost documents you can request a "Proof of Income" letter by contacting the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778) or www.ssa.gov, or contact your insurance carrier and request a document that contains the five items listed above.

☐ **Account Holder Information:**
The account holder may be the retiree or spouse, depending on your plan's 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.

☐ **Reimbursement Request Information:**
This section must be completed with a line for each premium reimbursement requested.

☐ **Action:**
A request must be submitted each time you have a new policy, at the first of a new year, when a change in your premium occurs or if a policy ends for any reason during the calendar year. Enter: "New Request", "Premium Change" or "End of Policy.

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 Date: This is usually January 1st of each new year or the effective date of the coverage period, such as when a participant becomes Medicare-eligible.

End Date: This is typically December 31st, or could be earlier if there is a change in your current plan, there is 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. You may request an amount that is less than the total premium or expense, if desired.

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

Direct Deposit!
Expedite your payments by signing up for direct deposit today. Refer to your Reimbursement Guide for instructions on how to log into the portal and complete the necessary information for your reimbursements to be made by direct deposit.