NORTH SHORE BANK

RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST

(Former) Employer Name:	From what initial date would you like reimbursements of your premium(s) to start?

Retiree/Employee Information

Retiree/Employee Name:	Last 4 of Social Security #:
Home Address:	Retirement Date:
Email:	Phone:

Individual Policy Information – This is required information and must be filled out completely to process your request.

Name of Insured Person:	
Name of Insurance Carrier:	
Type of Coverage:	
Plan Year/Policy Start Date:	Plan Year/Policy End Date*:
Total Monthly Individual Premium Amount Requested: Select Option for Receiving Reimbursement: ☐ **ACH TO EXTERNAL ACCOUNT OF FILE** ☐ **TRANSFER TO NORTH SHORE BANK ACCT #**_____ ☐ **MAIL CHECK TO PREVIOUS EMPLOYER** (**PLEASE PROVIDE PROOF OF COVERAGE FROM PREVIOUS EMPLOYER**)	

Employee Acknowledgement of Recurring Premium Reimbursement Request

Please initial next to each line to indicate you acknowledge the terms of this recurring premium reimbursement request.

_____ I understand that insurance premium claims are considered to be incurred on the first day of the month of coverage and that I cannot be reimbursed for expenses prior to that, regardless of the date the insurance bill was paid.

_____ I have attached a proof of my insurance coverage that includes the type of coverage, premium amount and contract period. Acceptable documents include a letter from the insurance company that includes the above information, a copy of a contract renewal letter or a letter from the former employer sponsoring the plan.

_____ *I understand that I will be set up for recurring reimbursement <u>until the plan year/policy end date</u>, when the rates will most likely change. I understand that I will need to complete a new form and send proof of insurance coverage when my insurance premiums change at the end of the plan year/contract or for any other reason.

_____ I understand that I am required to have <u>direct deposit</u> set up with North Shore Bank to receive claim reimbursements.

_____ In the event that my coverage is terminated for any reason, I am required to inform North Shore Bank within five (5) days of the termination so that future reimbursements can be stopped.

_____ I certify the above information is correct and the expenses claimed will incur on a regular basis by me or my eligible dependents after my effective date of coverage in my employer's Post Employment HRA Plan. I certify these expenses are not eligible for reimbursement under any other plan, and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return and I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

EMPLOYEE CERTIFICATION OF RECURRING EXPENSES AND CLAIMS FOR REIMBURSEMENT

Employee Signature: _____ **Date:** _____

North Shore Bank, Retirement Services STE 400, 15700 W Bluemound Rd., Brookfield WI 53005

Questions: 414-964-3390