State of Indiana Retirement Medical Benefits Account Plan Claim Form

This Signed Form Must Accompany Each Group of Receipts Submitted

Employee Last Name:	Employee First Name:	MI:	Social Security Number: H	980
Date of Birth:	Daytime Phone Number:	Email Address:		
Home Address:	City:	State:	Zip Code:	

☐ Please check if above information indicates changes

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 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: _____/_____/_____

Insurance Premium Expenses: Insurance Premium receipts or statements must: Be from an independent third party: Include the Name of the Retiree, Spouse or Covered Dependent, Name of the Provider, Type of Insurance; Include the month(s) covered, the Amount of the Insurance Premium and Proof of payment. If necessary, please add additional pages.
Medicare Reimbursements: You must have a current year Medicare letter on file.
Multiple Premium Coverage Periods – Coverage Periods are in the Past: Send a copy of your canceled check, statement showing dates covered and this signed claim form. Reimbursements will be processed according to the standard schedule.
Multiple Premium Coverage Periods – Coverage Periods are in the Future: Send a copy of your canceled check, statement showing dates covered and this signed claim form. Additionally verification must be sent to KBA each month that you are still the account holder or list an eligible dependent in the event of your death. Reimbursements will be processed according to the standard schedule.
Only PAST and the CURRENT month premiums are eligible for reimbursement. No future reimbursements are allowed under the Plan.

Name of Retiree of Covered Dependent	Month Covered	Name of Premium Provider	Coverage Notes	Amount of Premium
			Total Reimbursement Requested	

The following reimbursement request rules apply: *Please retain a copy of all receipts for your own records. Canceled checks are only acceptable as proof of payment not as receipts. This form must be signed and submitted with applicable receipts. For email submissions be sure to scan and attach all necessary documentation. For FAX submissions be sure all documents are orientated correctly for the equipment to scan the front of each page.*

Fax claims toll free to: 844-560-6757
Email claims to: KeyBenefit_Receipts@alegeus.com
Mailing Address: P.O. Box 1179 Fort Mill, SC 29716-1179

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Approved Substantiation for State of Indiana HRA Claims

When submitting a premium claim for your retirement medical reimbursement, KBA will need the following documentation each month, unless otherwise noted.

Important Note: Please be aware the State of Indiana's medical plans are eligible under the SB501 HRA - This account is NOT eligible for out-of-pocket medical costs, Premiums Only.

1. Claim Form, Signed by Retiree

2. Bill from Policy. Examples:

   a. If on Medicare Benefits:
      - The annual letter from Social Security outlining the payments being taken from your monthly stipend; each year if it changes.
      - A copy of the SSA annual letter to substantiate the amount indicated for reimbursement needs to be sent once a year, or if the amount changes.

   b. If 65 or older & have a Supplemental Policy:
      - A copy of the summary page indicating the cost and type of coverage.
      - Each month a claim is filed, attach a copy of the policy statement which indicates the monthly, quarterly or annual amount paid, plus eligible proof of payment, as shown below.

   c. If working at another employer:
      - Have employer provide a statement indicating the group insurance plan is fully-insured and premiums are not paid with pre-tax dollars.
      - Each month send a copy of paycheck stub for the month claimed for reimbursement; eligible for post-tax premiums only.

      Note: This benefit is not taxable by the IRS, therefore, premiums taken on a "pre-tax" basis cannot be reimbursed - most employers will pre-tax premiums; if you're still working with another employer, those premiums may not be eligible.

   d. If retired before eligible for Medicare benefits, and have a medical insurance policy:
      - A copy of the policy summary page indicating the cost and type of coverage.
      - Each month a claim is filed, attach a copy of the policy statement which indicates the monthly, quarterly or annual amount paid, plus eligible proof of payment, as shown below.

3. Eligible Proof-of-Payment**:**
      - Cancelled Check, Bank Statement, Credit Card Statement and Receipt for Cash Rendered for Payment, Statement from Insurance Carrier showing proof of payment, etc.

      - *NOTE: Claims must be made on a monthly basis to assure retiree or eligible dependent(s) are not deceased. Also, services and payments must be incurred before they are eligible to be reimbursed; we cannot pay ahead of the current month. If you are sending in premiums payments for coverage periods occurring in the future, you must send confirmation each month that you still the account holder or to whom as an eligible dependent, in the event you're your death, payments should be made.*