NDPERS Retiree Health Insurance Credit (RHIC) Program
Claim Form

Complete this claim form in its entirety, provide legible documentation as instructed, and sign below. Please print clearly.

Your Name (Last, First, MI)	NDPERS ID Number	Your Employer Name
		NDPERS Retiree Health Insurance Credit Program

Address	City	State	Zip Code

Insurance Premium Claims (other than Medicare)

Please include appropriate documentation as required by your employer plan with this completed claim form as follows:

- Itemized statement from the insurance company showing the dates for which premium is being paid, the type of insurance, the dollar amount of the premium; **and**,
- Proof of payment in the form of a pay stub, bank statement showing the debited amount, copy of the completed check or cancelled check, credit card receipt, electronic payment receipt, etc.

☐ ***Note to Medicare Enrollees:*** You can check here to request automatic recurring monthly RHIC reimbursement for Medicare Part B or D premiums deducted from your Social Security payment. To qualify you must complete this claim form and:

- **You must be signed up to receive reimbursement via direct deposit to your bank account.**
- You must submit a copy of your "Notice of Medical Insurance Enrollment and Premium Deduction", or "Proof of Income" letter from the Department of Health and Human Services (HHS). (No proof of payment required.)
- Submit this form once each calendar year, if you have a new plan, if the premium changes or if the coverage ends.

ASIFlex will automatically reimburse you each month for the Medicare premiums. Complete the information below to indicate the dates you wish to be reimbursed for and the monthly amount. See example in red below.

Date(s) of Insurance Coverage TO / FROM	Insurance Carrier	Insured Person/ Relationship	Type (Medical, Prescription)	Amount Requested	ASIFlex Use Only
Example: 1/1/22-12/31/22	Medicare	Self	Medicare Part B & D	$ 350/mo.	
				$	
				$	
				$	
				$	
				$	
			TOTAL	$	

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me while I was eligible under the NDPERS RHIC program, and that the premium expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that if I am eligible to receive a subsidy through the federal health care exchange, I am not able to receive RHIC reimbursement in addition to lower amounts paid for health insurance premiums. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.

SIGN HERE ➔ ➔ Signature _____ Date _____

FAX TO:
1-877-879-9038
PAGE _____ OF _____
NO COVER PAGE REQUIRED

MAIL TO:
ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

FILE ONLINE or by MOBILE APP:
WWW.ASIFLEX.COM
Claims may not be submitted by email
Phone Number: 1-800-659-3035