Complete all fields with your personal information

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

Check if eligible to claim **SS recurring premium payment** for the current plan year

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 insura[nce] 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 cancelled check, credit card receipt, electronic payment receipt, etc.

☐ ***Note to Medicare Enrollees:*** You can check here to request automatic recurring monthly RHIC reimburse[ment] 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 Incom[e]" 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 t[he] you wish to be reimbursed for and the monthly amount. See example in red below.

Enter the actual premium amount you pay for Part B.

ASIFlex is validating the claim amount against your Social Security (SS) letter. You should receive a SS letter from SS each year.

Your RHIC will be direct deposited into your bank account each month for this plan year.

You will take the amount times the number of months you are claiming and enter that in the "Total".

Date(s) of Insurance Coverage TO / FROM	Insurance Carrier	Insured Person/ Relationship	Type (Medical, Prescription)	Amount Requested
Example: 1/1/17-12/31/17	Medicare	Self	Medicare Part B & D	$ 350/mo.
				$
				$
				$
				$
				$
			TOTAL	$ 0.00

Enter months and years you are claiming (i.e. 1/1/2021 – 12/31/2021)

Enter Medicare. Self . Part B

Read acknowledgement, sign and date

[I certify th]at all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me wh[ile covered] under the NDPERS RHIC program, and that the premium expenses have not been reimbursed and reimbursement wi[ll 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 may not rec]eive RHIC reimbursement in addition to lower amounts paid for health insurance premiums. I understand that I [am responsible] for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is clai[med is a qualified exp]ense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax o[n amounts paid from] the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form a[nd documenta]tion.

Signature ______________________________ Date ________

FAX TO:	MAIL TO:	QUESTIONS:
1-877-879-9038	ASI	WWW.ASIFLEX.COM
PAGE ______ OF ______	PO BOX 6044	ASI@ASIFLEX.COM
NO COVER PAGE REQUIRED	COLUMBIA, MO 65205-6044	1-800-659-3035

NDPERS Rev

Complete claim form at the beginning of each plan year in January.
Send the claim form to ASIFlex with a copy of your Social Security letter that confirms Part A and B enrollment dates and premium amount paid for Part B.
RHIC not claimed by the March 31 deadline following the close of the RHIC plan year on December 31 is forfeited.