www.wexinc.com
1-844-561-1334 · 866-451-3245
PO Box 2926 · Fargo, ND 58108-2926

forms@wexhealth.com

# Automatic Premium Reimbursement Request Form

**Please note: this form can only be utilized for recurring Medicare Part B and Part D premiums. This for is not for WEX debit card claims. When submitting this form to WEX you must include documentation substantiating the Medicare premium.**

## Step 1: Participant Information

- Complete the required fields (*).
- Please write legible or type in the fields. Missing information may delay the processing of your claim.

## Step 2: Plan Information and Verification of Expenses

- Effective date: Enter the effective date (mm/dd/yyyy).
- Select one of the auto-reimbursement options:
  - Start auto-reimbursement
  - Change Auto-Reimbursement
  - Stop Auto-Reimbursement
- Plan type: HRA
- Monthly Premium: Provide the monthly premium amount requested.
- Plan Year Start Date: 01/01
- Plan Year End Date: 12/31
- Description of Product/Service: Provide a brief description of the service.
- Provide full name

## Step 3: Participant Certification

**Sign, date and submit the completed form, and required substantiation documentation to WEX:**

Mail: PO Box 2926; Fargo, ND 58108-2926
Fax: 1-866-451-3245
Email: forms@wexhealth.com

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# Automatic Premium Reimbursement Request Form

*=Required Fields

## Step 1: Participant Information

California Institue of Technology

*Employer Name (do not abbreviate)

Employee ID

*Participant Name (First, MI, Last)

*Social Security Number

## Step 2: Plan Information and Verification of Expenses

*Effective Date (mm/dd/yyyy)

*Please select only one of the below options:

| | |
|---|---|
| ☐ | **Start Auto-Reimbursement:** Please begin automatic reimbursement of any expenses effective by the date provided above. |
| ☐ | **Change Auto-Reimbursement:** Please update my automatic reimbursement information with the provided information effective by the date specified above. |
| ☐ | **Stop Auto-Reimbursement:** Please stop automatic reimbursement of my expenses effective by the date specified above. |

| *Plan Type | *Monthly Premium | *Plan Year Start Date (mm/dd/yyyy) | *Plan Year End Date (mm/dd/yyyy) | *Description of Product/Service |
|---|---|---|---|---|
| HRA | $ | | | |
| HRA | $ | | | |

**Plan Types Key:**
**HRA - Health Reimbursement Arrangement; RMSA - Retiree Medical Spending/Savings Account; IPA - Individual Premium Account**

I, _____, understand that my submission of this form is to be reimbursed automatically for the specified expense(s). Further, I understand if the attached expense(s) are less than my current account contribution, I will be reimbursed at the beginning of the month and not as my contributions post to the account.

**Reminder: Please provide documentation of the insurance premium amount and the type of insurance (e.g., Medicare Part B).**

## Step 3: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that WEX, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to notify WEX. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Pursuant to the terms of the plan, benefit payments that are not timely claimed may be forfeited back to the plan.

*Participant Signature

*Date (mm/dd/yyyy)