AUTOMATIC REIMBURSEMENT REQUEST FORM

DCP RETIREE MEDICAL PREMIUM REFUND

HUMAN RESOURCES
COLORADO STATE UNIVERSITY
www.hr.colostate.edu
970-491-6947
555 S Howes St | Fort Collins, CO
hr_retirement@colostate.edu

Step 1: Participant Information

Colorado State University
Employer Name

Date of Birth

Participant Name (First, MI, Last)

XXX-XX-
***Last 4-Social Security Number**

Step 2: Plan Information and Verification of Premiums

***Effective Date (mm/dd/yyyy)**

☐ **Start Auto-Reimbursement:** Please begin automatic reimbursement of any premiums effective 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 premiums effective the date provided above.

Plan Type (choose one)	**Monthly Premium**	**Plan Year Start Date** (mm/dd/yyyy)	**Plan Year End Date** (mm/dd/yyyy)	**Health care plan name**

I, _____ understand that my submission of this form is to be reimbursed automatically for the specified health care plan premiums.

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 premiums and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that WEX Health, Inc., 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 Health, Inc. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

I understand that the University cannot, under Federal regulations applicable to this medical premium refund, provide a refund in excess of the actual cost of my medical coverage (vision and dental premiums are not eligible). The actual cost of my medical coverage means the actual premium amount required to cover myself and does not include premium amounts for my spouse and/or dependents' medical coverage. I understand that my DCP refund will begin on the first of the month following receipt of this certification, and retroactive payments will not be issued if the form is not submitted timely.

I understand that, as is the case with all such programs, The Board of Governors of the Colorado State University System reserves the right to amend or terminate this program at its sole discretion at any time.

Retiree Signature

Date

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