RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST FORM

Submit this form and your coverage documents via one of the following methods.	Online	Fax	Mail
	Sign in at cda.basiconline.com and go to *Support › Contact Us* to submit a support request.	608-245-3623	PO Box 7308 Madison, WI 53704-7308

Important: A new form must be submitted each year when your policy rate changes (beginning of new plan year or policy end date) to update your recurring reimbursements with your new rate. Refer to Additional Instructions on page 2.

PARTICIPANT INFORMATION

Participant Name		Employer Name *(Former employer for retirees)*	
Participant ID (12-digit)		Email Address	

INDIVIDUAL POLICY INFORMATION & REQUEST FOR REIMBURSEMENT

Name of Insured Person			
Name of Insurance Carrier			
Type of Coverage			
Premium Reimbursement Start Date		Premium Reimbursement Amount End Date	
Monthly Premium Amount Requested		Total Plan Year Premium Amount Requested	

Name of Insured Person			
Name of Insurance Carrier			
Type of Coverage			
Premium Reimbursement Start Date		Premium Reimbursement End Date	
Monthly Premium Amount Requested		Total Plan Year Premium Amount Requested	

Name of Insured Person			
Name of Insurance Carrier			
Type of Coverage			
Premium Reimbursement Start Date		Premium Reimbursement End Date	
Monthly Premium Amount Requested		Total Plan Year Premium Amount Requested	

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Monthly Premium Amount Requested		Total Plan Year Premium Amount Requested	

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ADDITIONAL INSTRUCTIONS

Submit this form and your coverage documents via your online account:

1. Sign into your account at cda.basiconline.com.
2. Form the menu, select *Support › Contact Us*.
3. Select the offering type *Benefit Plans*, then *Expenditures*, then *Create or adjust a recurring claim*.
4. Complete the requested information and click *Upload a file for reference*.
5. Select your form and documentation to attach and click *Open*. Files must be in JPG, JPEG, PNG, or PDF format.

How to set up direct deposit:

1. Sign into your account at cda.basiconline.com.
2. From the menu, select *Settings › Bank accounts*.
3. Click *Link new bank account*.
4. Enter your banking information and click *Link*.
5. Go to the *Overview* and select your *MyCash balance*, then *Schedule a balance transfer*.
6. Select your schedule preferences and click *Submit*.

AUTHORIZATION – Section 1

Initial next to each line below to indicate you acknowledge the terms of this recurring individual premium reimbursement request.

_____I understand that (1) I will be set up for a monthly recurring reimbursement as requested above and this recurring reimbursement will continue through the Premium Reimbursement Amount End Date indicated above. (2) If no end date is listed, the premium reimbursements will stop at the end of my employer's benefit plan year and will not continue until a new *Recurring Individual Premium Reimbursement Request Form* is submitted. (3) The amount reimbursed is limited to my current available benefit account balance.

_____I understand that insurance premiums are considered to be incurred on the first day of the month of coverage and that I cannot be reimbursed for expenses prior to that, regardless of the date the insurance bill was paid.

_____I have attached proof of my insurance coverage that includes the type of coverage, premium amount, and contract period. Acceptable documents include a letter from the insurance company that includes the above information, a copy of a contract renewal letter, or a letter from the former employer sponsoring the plan.

_____I understand that I am required to complete a new *Recurring Individual Premium Reimbursement Request Form* for each plan year and send proof of insurance coverage when my insurance premiums change (at the start of the new plan year, the end of the policy contract, or for any other reason).

_____I understand that I am required to have direct deposit set up with BASIC to receive reimbursements.

_____In the event that my coverage is terminated for any reason, I am required to inform BASIC within five days of the termination so that future reimbursements can be stopped.

_____I certify the above information is correct and the expenses claimed will be incurred on a regular basis by me or my eligible dependents after my effective date of coverage in my employer's benefit plan. I certify these expenses are not eligible for reimbursement under any other plan and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return and I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

AUTHORIZATION – Section 2

I certify that I have read, understand, and agree to the requirements above. I request the premium amount indicated above to be disbursed from my available benefit account balance each month.

_____ _____

Participant's Signature Date