University of Pittsburgh

Defined Dollar Benefit Reimbursement Request Form

1. Participant Information (Please print or type all information)

_____ _____
Participant Last Name, First, Middle Member Id

_____
Street Address, City, State, Zip Code

☐ I would like to receive email confirmations that my reimbursement form has been received _____
E-mail Address

2. Expenses: I request reimbursement of the following expenses for premiums paid for retiree medical coverage:

☐ **Recurring Reimbursement (Monthly)**

***Future month payments will be disbursed monthly before the 15th of each month until the ending date listed below**

Insurance Company(s) Name

_____

Reimbursement Period: (12 Month period or less)

M:_____/**Y:**_____
To
M:_____/**Y:**_____

Monthly amount to Be Reimbursed

$_____

☐ **One Time Reimbursement (Single Payment)**

***Please note that we are unable to process one time claim reimbursements before the months requested. If you choose the MULTIPLE MONTH reimbursement the full amount will be disbursed after the first day of the last month requested.**

Insurance Company(s) Name

_____

Requested Reimbursement Period

☐ **Single Month- M:**_____/**Y:**_____

☐ **Multiple Months- M:**_____/**Y:**_____
To
M:_____/**Y:**_____

Full Amount to Be Reimbursed

$_____

NOTE: Documentation required is a copy of the insurance company invoice and this completed and signed claim form. The copy of the invoice from the insurance company must include the period for which you are paying, the amount of the premium, the name of the insurance company and the type of policy. **Reimbursements must be submitted no later than 6 months following the end of the plan year.**

3. Participant Signature (Please sign this form and provide a phone number where you can be reached)

- The information furnished by me in support of this application for reimbursement is true and correct to the best of my knowledge.
- I understand that the expenses submitted for reimbursement must qualify under the provisions of the plan. I further understand that should I be reimbursed more than I am entitled, I will take responsibility for returning any / all reimbursements resulting from an error, change in coverage, or other family status change.
- I hereby authorize any individual or organization to release any information requested by UPMC Benefit Management Services with respect to this specific request.

_____ (_____) _____ _____/_____/_____
Participant Signature Phone Number Date

Please return your completed form and documentation:

Email: PITT-BMSdocs@upmc.edu ***Please allow approximately 14 business days to receive your reimbursement***

Fax: 1-877-851-5591 ***Please allow approximately 14 business days to receive your reimbursement***

Mail: UPMC Benefit Management Services
US Steel Tower
600 Grant Street UST 01-11-01
Pittsburgh PA 15219

Please allow approximately 30 days to receive your reimbursement

The University of Pittsburgh Retiree Benefit Service Center Hotline 888-499-6885