



# Defined Dollar Benefit Reimbursement Request Form

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

Participant Last Name, First, Middle

Social Security Number

Street Address, City, State, Zip

Is this a new address since your last request for disbursement?  Yes  No

## 2 Expenses

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

Insurance Company	Coverage Period	Total Premium Paid	Amount to be Reimbursed
_____	____/____/____ TO ____/____/____	\$ _____	\$ _____
<b>TOTAL SUBMITTED FOR DDB REIMBURSEMENT →</b>			<b>\$ _____</b>

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, the type of policy, and covered participants.

## 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 and 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 EBDS with respect to this specific request.

Participant Signature

(\_\_\_\_) Phone Number

\_\_\_\_/\_\_\_\_/\_\_\_\_ Date

### MAIL COMPLETED FORM AND DOCUMENTATION TO:

EBDS Flex Claims, One Gateway Center, Suite 1250, 420 Fort Duquesne Boulevard, Pittsburgh, PA 15222-1437

The University of Pittsburgh Retiree Benefit Service Center Hotline: 800-521-5561