Benefit Resource, LLC
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HEALTH REIMBURSEMENT ACCOUNT (HRA)

Recurring Premium Attestation Form

Please keep the following in mind regarding recurring premium reimbursements:

- A new Recurring Premium Attestation Form, along with Claim form and receipt, must be submitted for each plan year.
- If you are submitting this via BRIWEB or BRIMOBILE, please complete and attach along with your completed claim form and receipt (Premium statement clearly showing monthly amount).
- If you are submitting this via mail, please complete and attach along with your completed claim form and receipt (Premium statement clearly showing monthly amount) and send to the address above.

Plan Year _____ Member ID _____

Last Name _____ First Name _____ Middle Initial _____

Company _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email _____

For recurring Medicare Supplement and/or Medicare Part B or individual health care premium claims. **Please attach your insurance premium statement or bank statement showing the deduction amount(s).**

☐ I authorize BRI to automatically reimburse the monthly amount above for my Medicare Supplement or individual health care premiums.

Please complete and attach the Direct Deposit form (https://forms.benefitresource.com/direct_deposit.pdf) to initiate reimbursements accordingly if you have not already set up direct deposit for your account.

For which months and amount would you like to be reimbursed recurring monthly?

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June

☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

☐ ALL MONTHS Amount _____

☐ I understand that it is my responsibility to inform BRI, the plan administrator, if my premium changes. I understand I must provide written documentation if the amount to be reimbursed changes.

Signature _____ Date _____