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 _____