Premium Continual Reimbursement Form

1 Personal Information

Company Name | Employee Email Address

Employee Name | Employee Social Security Number (Required)

Employee Street Address, | City, | State, | Zip Code

Instructions

1. Complete this form with monthly premium amount and coverage period
2. Please send the completed form to National Benefit Services, LLC with a copy of your contract that shows the monthly premium amount and coverage dates

2 Premium Information

Provider Name # 1	Monthly Premium Amount	Coverage Period to
Provider Name # 2	Monthly Premium Amount	Coverage Period to
Provider Name #3	Monthly Premium Amount	Coverage Period to
Provider Name #4	Monthly Premium Amount	Coverage Period to

3 Direct Deposit Request

Your Financial Institution

☐ Checking Account ☐ Savings Account
Account Type

Financial Institution Address

Routing Number | Account Number

4 Continual Reimbursement

Premium expenses reimbursed under the plan cannot be paid prior to the beginning of the coverage period. It is the participant's responsibility to advise the plan administrator of any increases or decreases in premium cost as well as the cessation or interruption of such premiums

You may use this form to apply for continual reimbursement. No reimbursement may be paid under the continual reimbursement program for any month in which Health Care premiums are not applicable. It is your responsibility to advise the plan administrator of any increases or decreases in premium cost as well as the cessation or interruption of such premiums.

☐ **YES! Please sign me up for continual reimbursement**
Your reimbursement will automatically be sent to you after each payroll period.

5 Employee Signature

I have reviewed the information on this request form and verify that the information listed above and attached is true and correct. I understand that if any changes regarding the continual payment occur, NBS must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible. **I also understand that copies of receipts for payment of the premium(s) must be forwarded to NBS.**

Employee Signature | Date

P.O. Box 6980 West Jordan, UT 84084 • (855) 399-3035 • Fax (844) 438-1496 • my.nbsbenefits.com