Account Reimbursement Form

Participant Name:

Last 4 of SSN:

Employer Name:

Reason for return of funds (to satisfy a balance due, provider or insurance issued a refund, etc.):

If this is a Provider Refund:

Provider Name:
Transaction date:
Transaction amount:

Additional information:

Please mail with check or money order to:

National Benefit Services
P.O. Box 219393
Kansas City, MO 64121-9393