



# RECURRING INDIVIDUAL PREMIUM REIMBURSEMENT REQUEST FORM

Submit this form and your coverage documents via one of the following methods:	<b>Online or Mobile App</b>	<b>Fax</b>	<b>Mail</b>
	Sign into your account and submit via a Support Request (click CONTACT US). <a href="#">Additional Instructions on page 2.</a>	269-372-0716	BASIC, PO Box 6278 Monona, Wisconsin 53716-6278

**Important:** A new form must be submitted each year when your policy rate changes\* (beginning of new plan year or policy end date) to update your recurring reimbursements with your new rate. Refer to Additional Instructions on page 2.

Employer Name: (Former Employer for Retirees)	
Employer BASIC ID #:	

## PARTICIPANT INFORMATION

First Name:		MI:		Last Name:	
BASIC ID # (required):		Email Address:			
Primary Phone #:		Mobile Phone #:			
Primary Address: (cannot be PO Box)	Address 1:			Apt:	
	Address 2:				
	City:				
	State:		ZIP Code:		+4:

**Important:** All information below is required to be completed in full to process your request, including the Authorization Section 1 and Section 2.

## INDIVIDUAL POLICY INFORMATION & REQUEST FOR REIMBURSEMENT

Name of Insured Person:			
Name of Insurance Carrier:			
Type of Coverage:			
Start Date for Premium Reimbursement:	___/___/___	End Date for this Premium Reimbursement Amount*:	___/___/___
Monthly Premium Amount Requested:	\$ _____	Total Plan Year Premium Amount Requested:	\$ _____

## AUTHORIZATION – Section 1

I certify that I have read, understand and agree to the requirements above and in the Authorization – Section 2. I request the monthly premium amount indicated above to be reimbursed from my available account balance each month.

\_\_\_\_\_  
Authorized Signature (may be digital signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

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## AUTHORIZATION – Section 2

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Initial next to each line below to indicate you acknowledged the terms of this recurring premium reimbursement request.

\_\_\_\_\_ I understand that (1) I will be set up for a monthly recurring reimbursement as requested above and this recurring reimbursement will continue through the “End Date for this Premium Reimbursement Amount” indicated above. (2) If no end date is listed, the reimbursements will stop at the end of my employer’s premium benefit plan year and will not continue until a new Recurring Individual Premium Reimbursement Request Form is submitted. (3) The amount reimbursed is limited to my current available account balance.

\_\_\_\_\_ I understand that insurance premiums are considered to be incurred on the first day of the month of coverage and that I cannot be reimbursed for expenses prior to that, regardless of the date the insurance bill was paid.

\_\_\_\_\_ I have attached a proof of my insurance coverage that includes the type of coverage, premium amount, and contract period. Acceptable documents include a letter from the insurance company that includes the above information, a copy of a contract renewal letter, or a letter from the former employer sponsoring the plan.

\_\_\_\_\_ \*I understand that I am required to complete a new Recurring Reimbursement Request form for each plan year and send proof of insurance coverage when my insurance premiums change (at the start of the new plan year, the end of the policy contract, or for any other reason).

\_\_\_\_\_ I understand that I am required to have direct deposit set up with BASIC to receive reimbursements.

\_\_\_\_\_ In the event that my coverage is terminated for any reason, I am required to inform BASIC within five (5) days of the termination so that future reimbursements can be stopped.

\_\_\_\_\_ I certify the above information is correct and the expenses claimed will incur on a regular basis by me or my eligible dependents after my effective date of coverage in my employer’s benefit plan. I certify these expenses are not eligible for reimbursement under any other plan and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return and I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

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## ADDITIONAL INSTRUCTIONS

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Easily submit this form and your coverage documents via your online account or the mobile app.

1. Sign in to your account at [cda.basiconline.com/login](http://cda.basiconline.com/login).
2. From the OVERVIEW page, select CONTACT US.
3. Choose the topic EXPENDITURES, sub-topic I’D LIKE TO KNOW HOW TO REQUEST A REIMBURSEMENT, select SEND A SUPPORT REQUEST and NEXT.
4. Complete the requested information and select UPLOAD a FILE FOR REFERENCE.
5. Select your form and documentation to attach and select OPEN: Upload a FILE FOR REFERENCE. Please note, uploaded forms must be in JPG, JPEG, PNG, or PDF format. (If submitting via your mobile phone, simply take a picture of your forms and upload.)

Set up Direct Deposit.

1. Sign in to your account at [cda.basiconline.com/login](http://cda.basiconline.com/login).
2. Select SETTING and then BANK ACCOUNTS.
3. Select LINK NEW BANK ACCOUNT.
4. Enter your banking information and select LINK.
5. Go back to the OVERVIEW page and select MYCASH BALANCE and MANAGE MYCASH TRANSFER SCHEDULES.
6. Select SCHEDULE A NEW TRANSFER, select your schedule preference and SUBMIT.

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The information contained in this communication is confidential and to be used by BASIC employees and representatives for only its intended purpose.

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