inspira™ FINANCIAL

Health Reimbursement Arrangement (HRA) / Retiree Reimbursement Arrangement (RRA) Recurring Premium Reimbursement Claim Form

Mail or Fax completed form and documentation to:
Inspira Financial
PO Box 2495
Omaha, NE 68103
Fax: 888-238-3539
888-678-8242 (TTY: 711)

This form can only be used if this is an option offered by your employer.

To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.
You can get claim forms online. To get started, log in to the Inspira Mobile app or your Inspira Financial member website.
You can also find instructions online for completing this form.

Member Identification Number *(Employer/Member assigned number or W ID)*	**Member Full Name** *(Last Name, First, MI)*
Member Address *(Street, City, State, ZIP Code)*	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name

Insurance Premium Expenses

This form is to be used when your plan allows recurring reimbursements of health care premiums. Recurring Premium requests must be resubmitted each Plan Year, if you have a new policy, if the premium changes or if a policy ends.

NOTE: For Medicare premiums (deducted from your Social Security check): If this is the first time this calendar year you are requesting reimbursement of premiums, enclose a copy of your "Notice of Medical Insurance Enrollment and Premium Deduction" , also called "Proof of Income" letter. This is from the Department of Health and Human Services (HHS). For lost documents you may contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Note: Premiums that you pay pre-tax are not eligible expenses.

If this is a request for insurance premium expenses other than Medicare, enclose a copy of the appropriate supporting documentation. Supporting documentation must include the covered individual's name, insurance carrier's name, type of coverage, dates of coverage, and monthly premium amount.

Covered Eligible Person's Name	**Action: Enter one of the following**			**Type of Premium** (Medicare, Medigap, Medical, Dental, etc.)	**Annual Social Security Administration Letter** If previously submitted, please check Yes	**From Date of Service** MM/DD/YYYY	**To/Thru Date of Service** MM/DD/YYYY	**Monthly Amount Requested**
	New Policy	**Premium Change**	**End of Policy**					
	☐	☐	☐		☐ Yes			$
	☐	☐	☐		☐ Yes			$
	☐	☐	☐		☐ Yes			$
	☐	☐	☐		☐ Yes			$
	☐	☐	☐		☐ Yes			$
	☐	☐	☐		☐ Yes			$
****If more lines are needed, please complete another form.**							**Total**	**$** 0.00

I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible premiums. I understand that this does not include premiums paid with pre-tax salary reduction. (Premium that is paid pre-tax is not an eligible expense.) I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. Upon receiving notice of a change in premium or a cancellation of coverage, I will notify Inspira Financial immediately. I have received and read the printed materials for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Member Signature	**Date**
✍	

******If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.******