www.wexinc.com
Phone: 844-440-4300
Submit your completed form by:
Mail: WEX, PO Box 2926, Fargo, ND 58108-2926
Fax: 866-451-3245
Email: forms@wexhealth.com

Recurring Premium Reimbursement Request Form

*=Required Fields

This form is used to request automatic reimbursement for Medicare premium expenses.

Step 1: Member Information

UAW Retiree Medical Benefits Trust

*Member Name (First, MI, Last)

If you need assistance filling out this form, please call WEX at **844-440-4300**

*Social Security Number

Step 2: Plan Information and Verification of Expenses

This form is to initiate or change a recurring reimbursement and will not apply to previously submitted claims. If you previously used a debit card for a charge or have already submitted a one-time claim for reimbursement, you will need to submit documentation for that claim separately.

*Please select only one of the below options:

☐	**Start Auto-Reimbursement:** Please begin automatic reimbursement of my expenses effective as of the Start Date of Reimbursement listed below.
☐	**Stop Auto-Reimbursement:** Please stop automatic reimbursement of my expenses effective as of the End Date of Reimbursement listed below.

Plan Type	*Monthly Premium	*Start Date for Reimbursement (mm/dd/yyyy)	*End Date for Reimbursement (mm/dd/yyyy)	*Description of Product/Service
HRA	$		Recurring monthly reimbursement will continue until plan year balance is exhausted or until the end date provided below.	Medicare Premium
HRA	$		Recurring monthly reimbursement will continue until plan year balance is exhausted or until the end date provided below.	

Step 3: Required Premium Expense Documentation

For Medicare premium reimbursement, please provide a copy of your Annual Benefit Statement from the Social Security Administration. For all other premium expense types, please submit appropriate documentation. Ensure documentation is from the same year as the dates you entered above, is legible and indicates the cost of your premiums.

Step 4: Member Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that WEX Health, Inc., including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to notify WEX Health, Inc. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit. Pursuant to the terms of the plan, benefit payments that are not timely claimed may be forfeited back to the plan.

I understand that my submission of this form is to be reimbursed automatically for the specified expense(s). Further, I understand if the attached expense(s) are less than my current account contribution, I will be reimbursed at the beginning of the month.

*Member Signature

*Date (mm/dd/yyyy)