



# Premium Reimbursement Account

Please mail, fax or email completed forms to:  
 Health Equity Claims  
 15 West Scenic Pointe Drive, Suite 400 Draper, UT 84020  
**Fax:** 801-999-7829  
**Email:** reimbursementaccounts@healthequity.com

<b>Participant Information</b> <input type="checkbox"/> Change of Address			
Company Name		Employee Social Security #	
Last Name	First Name	M.I.	
Street Address	City	State	Zip
E-Mail Address	Home Phone # (area code)	Work Phone # (area code & ext.)	

<b>Premium Reimbursement Accounts</b>				
Coverage Period Start	Coverage Period End	Insured Name	Type of Insurance	Amount
___/___/___	___/___/___			\$
___/___/___	___/___/___			\$
___/___/___	___/___/___			\$
___/___/___	___/___/___			\$
___/___/___	___/___/___			\$
			<b>Total (Required)</b>	<b>\$</b>

**Certification:**  
 I request reimbursement for the premium expense listed above. I have attached appropriate receipts or third party proof that I have incurred these expenses within the plan year and during the benefit period under this plan. I certify that I have not been reimbursed for these expenses under our insurance or under any other source. I understand that I cannot claim these expenses on my personal tax return.

Participant Signature	Date
-----------------------	------

**Note:**  
 Please attach proper documentation to this form. A premium invoice is required. Documentation must include the coverage period, the name of the insured, the name of the carrier, description of the services and the cost.  
 If you have additional expenses, please complete an additional form. **Do not send original receipts.**