



# PRA REIMBURSEMENT REQUEST FORM

*For PRA [Premium Reimbursement Account] Qualifying Individually Owned Insurance Premium Expense*

**NOTE:** This form **MUST** be completed to receive reimbursement for out-of-pocket Individually Owned Insurance Premium expenses for your Premium Reimbursement Account. These services **MUST** have been incurred during the current Plan Year. **A copy of the Insurance Policy must be submitted initially to verify that the coverage is not sponsored by an employer and solely individually owned. Each reimbursement request must be accompanied by a receipt from your insurance carrier indicating payment for a particular coverage period. Your claim will not be processed until these items are received by MGIS. Credit card receipts or cancelled checks cannot be accepted.**

FAX COMPLETED FORM AND ALL DOCUMENTATION TO: **MEDICAL GROUP INSURANCE SERVICES, INC.**  
CLAIMS FAX: 866.969.4446

PLEASE COMPLETE ENTIRE FORM. PRINT OR TYPE (USE ADDITIONAL SHEETS IF NECESSARY)

<b>EMPLOYER NAME:</b> _____		<b>PLAN YEAR:</b> _____	
<b>EMPLOYEE NAME:</b> _____ <small>LAST FIRST MI</small>		<b>SOCIAL SECURITY NUMBER:</b> _____ - _____ - _____	
<b>EMPLOYEE HOME ADDRESS:</b> _____ <small>NUMBER AND STREET CITY STATE ZIP</small>			
<input type="checkbox"/> CHECK HERE IF THIS IS A CHANGE IN ADDRESS			
<b>EMPLOYEE DAY PHONE:</b> (    ) _____		<b>EMPLOYEE E-MAIL:</b> _____	
<b>INDICATE WHICH COVERAGES YOU HAVE:</b> (CHECK ALL THAT APPLY)		<b>IS A SPOUSE AND/OR DEPENDENT INCLUDED:</b> UNDER THIS COVERAGE?: (CHECK ONE)	
<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION		<input type="checkbox"/> YES <input type="checkbox"/> NO	

### UNREIMBURSED INSURANCE PREMIUM EXPENSES (QUALIFYING INDIVIDUALLY OWNED INSURANCE POLICIES)

COVERED PERIOD		POLICY HOLDER'S NAME	INSURANCE CARRIER	AMOUNT
START DATE	END DATE			
<b>Credit card receipts or cancelled checks cannot be accepted.</b>				
<b>TOTAL UNREIMBURSED PRA CLAIMS</b>				\$

### INSURANCE CARRIER INFORMATION (THIS SECTION MUST BE COMPLETED FOR REIMBURSEMENT)

<b>INSURANCE CARRIER:</b> _____	<b>POLICY #:</b> _____
<b>ADDRESS:</b> _____	<b>TYPE OF COVERAGE:</b> _____

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Premium Reimbursement Account. I am claiming reimbursement only for eligible expenses incurred by myself for my spouse and/or covered dependents (for PRA reimbursement, these expenses must have been incurred during the Plan Year shown above) and certify that these expenses have not been reimbursed under this Plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my Premium Reimbursement Account to be reduced by the amount(s) shown above.

PARTICIPANT'S SIGNATURE <b>X</b> _____	DATE _____
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If you have questions or need assistance, call the number listed below or visit our website.