MEDSURETY

Maximize Your Health Savings

Automatic Recurring Premium Reimbursement Request Form

(To be returned to MEDSURETY Along with a premium statement from your carrier)

This form is: ☐ New Request

☐ Replacing previous carrier: _____

☐ Cancelation of current reimbursement – Effective: _____

Participant/Account Holder Information:

Account Holder Name: _____ Last 4 of SSN:_____

Former Employer: _____

Start Date for Reimbursement: _____

Carrier Name: _____

Insurance Type: _____

Start Date of Reimbursement: _____

Monthly Premium Amount: _____

Initial Next to the following statements to indicate you have read and agree:

_____ I understand that I must sign up for Direct Deposit of my funds in order to participate in this program. Check reimbursements will not be allowed.

_____ I understand that reimbursements occur on the first reimbursement run of each month for premiums paid that month.

_____ I agree that it is my responsibility to keep MEDSRUETY informed timely of any insurance changes that result in a change of my premiums and adjustments to this reimbursement.

_____ I understand that this form is valid for 12 months of reimbursements and that it is my responsibility to file a new recurring claim for the next premium year.

Participant Signature: _____Date:_____

Return to: MEDSURETY LLC
18001 Highway 7, Suite 204
Minnetonka, MN 55345
Email: customerservice@medsurety.com
Fax: (952) 856-2656