AMERICAN BENEFITS GROUP

RETIREE MEDICAL PREMIUM REIMBURSEMENT CLAIM FORM

Consolidated Communcations

Participant Name: _____ Last Four Digits of SNN:_____

Participant Address: _____

Phone Number: _____ Email Address: _____

Items Required to Process Reimbursement Claims Under the Retiree Medical Premium Reimbursement Program:

- Name and Address of Covered Retiree and Spouse, if applicable
- Name and Address of the Insurance carrier or plan premiums were paid to
- Amount of premiums paid, including a breakout of the amount attributable to self-only coverage and to spouse coverage
- The date premiums were paid and for what period they were paid for
- Documentation from the insurance carrier or plan verifying the information above, such as paid invoices, confirmation of payment etc.
- Retiree's statement verifying that premiums have not been reimbursed and are not otherwise reimbursable from any other source

You have 45 days from the date you pay your monthly premium to submit your claim.

Description		Premium Start Date	Premium End Date	Amount
			Total Premiums	

Participant Signature: _____ Date: _____

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