



# AMERICAN BENEFITS GROUP

## RETIREE MEDICAL PREMIUM REIMBURSEMENT CLAIM FORM

### Consolidated Communications

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:

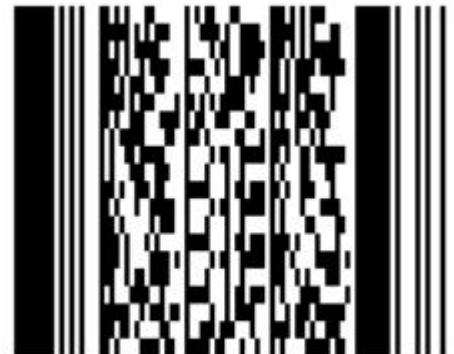
- Name and Address of Covered Retiree and Spouse, if applicable
- Name and Address of the Insurance carrier or plan premiums were paid to
- Amount of premiums paid, including a breakout of the amount attributable to self-only coverage and to spouse coverage
- The date premiums were paid and for what 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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