Clear Form

Hospital & Other Insurance Premium Request Form

Use this form for reimbursement of individual premiums paid to your insurance provider for you, your spouse or any federal tax dependents. Individual insurance premium expenses are only reimbursable if your employer offers an Other Insurance Premium Reimbursement Account.

INSTRUCTIONS

1. **Complete** all applicable sections of this form including your signature and the current date.
2. **Submit** your completed form to Igoe Administrative Services via:
   - Secure Upload through your personal account at www.goigoe.com
   - Email to flex@goigoe.com
   - Fax to 800-456-9083
   - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
3. **Tips**
   - Reimbursements are issued based on your current account balance. Remember that as you make deposits to the account, they become available to you for reimbursement.
   - Service dates must have already been incurred or may be requested up to one month in advance.
   - Supporting documentation must show the name of the insured, coverage paid through dates, provider and total amount paid.
   - Group insurance premiums paid are NOT eligible for reimbursement through this Plan.
   - Please allow up to 4 business days for your completed request to be updated online.
   - Specific information regarding reimbursement release dates can be located in your Flexible Benefit Plan Highlights. Additional copies of your Flexible Benefit Plan Highlights can be requested by emailing Igoe Administrative Services at flex@goigoe.com
   - Remember to keep original receipts for your records as you may be required to provide documentation directly to the IRS in the event of a personal audit. All supporting documentation becomes a part of your request and will not be returned to you.
4. **Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Clear Section A

Employer Name

Participant Name	Number of pages	First 5 digits of the Participant SSN – -####	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Premium Insurer Expenses Incurred (for participant and all federal tax dependents)

Clear Section B

Period Covered (MM/DD/YYYY - MM/DD/YYYY)	Name of Insurance Provider	Description of Expense	Name/Relation For Whom Expense Incurred	Net Amount
-				$
-				$
-				$
-				$
-				$
			Total	$ 0.00

Section C: Authorization *REQUIRED (PLEASE SIGN AND DATE)

As a participant in the Plan, I certify that all above expenses were incurred during the Plan Year while I was covered under the Flexible Benefit Plan and that the expenses have not been or are not being reimbursed under any other benefit plan and have not been deducted on a pre-tax basis. I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to this request. Each expense for which payment or reimbursement is requested must be a proper expense under the Plan. If not, I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE. I authorize the account in my name to be reduced by the amount requested.

Signature: Ready To Sign? Click To Print ***Date:*** _____

IGOE ADMINISTRATIVE SERVICES