NDPERS Retiree Health Insurance Credit (RHIC) Program
Claim Form

Complete this claim form in its entirety, provide legible documentation as instructed, and sign below. Please print clearly.

Your Name (Last, First, MI)	NDPERS ID Number	Your Employer Name
		NDPERS **Retiree Health Insurance Credit Program**

Address	City	State	Zip Code

Insurance Premium Claims (non-Medicare): New documentation is required every time there is new premium coverage/type or a rate change. Submit this completed claim form with the following required documentation:

- Proof of Insurance – Itemized statement from the insurance company or employer showing month(s) for which premium is being paid, the type of insurance, the dollar amount of the premium; **and**,
- Proof of payment – Includes employer pay stub showing after-tax deduction amount, bank statement showing the debited amount, copy of the completed check or cancelled check, credit card receipt, electronic payment receipt, etc.

Medicare Premium Claims: Automatic recurring monthly RHIC reimbursement can be setup. Submit this completed claim form each calendar year or if you have a change in coverage (new plan, premium change, or coverage ends) with the following :

- Direct Deposit – You must be signed up to receive reimbursement via direct deposit; **and**,
- Benefit Verification Letter from the Social Security Administration – Must show the amount of Medicare Part B or D premiums deducted directly from your monthly Social Security payment for the current open plan year (No proof of payment required)

Complete the information below to confirm the dates of reimbursement for documentation being submitted. **See example.**

Date(s) of Insurance Coverage TO / FROM	Insurance Carrier	Insured Person/ Relationship	Type (Medical, Prescription)	Premium Amount Paid	ASIFlex Use Only
Example: 1/1/23-12/31/23	**Medicare**	**Self**	**Medicare Part B & D**	**$ 350/mo.**	
				$	
				$	
				$	
				$	
				$	
			TOTAL	**$**	

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me while I was eligible under the NDPERS RHIC program, and that the premium expenses have not been reimbursed and reimbursement will not be sought from any other source. **I understand that if I am eligible to receive a subsidy through the federal health care exchange, I am not able to receive RHIC reimbursement in addition to lower amounts paid for health insurance premiums.** I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation. **Claim forms submitted to the NDPERS office will be returned to the member and will not be accepted.**

SIGN HERE ➔ ➔ Signature _____ Date _____

FAX TO:
1-877-879-9038
PAGE _____ OF _____
NO COVER PAGE REQUIRED

MAIL TO:
ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

FILE ONLINE or by MOBILE APP:
WWW.ASIFLEX.COM
Claims may not be submitted by email
Phone Number: 1-800-659-3035