Nationwide® Retirement Solutions
On Your Side™

PEHP CLAIM FORM

I. Personal Information

Name (Please Print)

Social Security Number

Date of Birth

Home Address

City

State

Zip Code

Home Telephone Number

Work Telephone Number

Employer Name/Plan Number *(if applicable)*: City of Tulsa / UC3600-1F2

Email Address

II. Reimbursement

NOTE: Please Attach Receipts of paid medical expenses/proof of paid premium expenses (i.e. medical bills, prescription receipts, health insurance statements)

Reimbursement Is For: ☐ **Self** ☐ **Spouse** ☐ **Dependent***

**** If Reimbursement is for Dependent: (for multiple dependents please attach on a separate page)***

Spouse/Dependent Name **Date of Birth**

Relationship

Reimbursement Amount: $ ☐ **One-time** ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

III. Severance of Employment Verification

This section must be completed by your Payroll Department, only if this is an initial payout request.

Signature of Certifying Official

Separation from Service Date

IV. Automated Deposit Authorization

I hereby authorize my PEHP plan provider, hereinafter called COMPANY, to initiate credit entries to my account indicated below in the financial institution named below. I specifically agree to hold harmless and not seek recovery against the COMPANY, its officers, directors, employees and agents for any loss which I may sustain due to the actions or inactions of my designated financial institution or the information contained in this form. The credit entries will represent payments due to me under the Post Employment Health Plan. This program will begin within 30-45 days after receipt of this notification, after which all payments will be made to my account within **3 business days** following the withdrawal. By signing this form, I agree to direct my executors, administrators, or assignees to refund any payments which are made for any period following my death so they may be redistributed to my beneficiary if applicable. Note: Your financial institution must be a member of the Automatic Clearing House (ACH). Call your financial institution if you are unsure.

For deposits to your financial institution, please complete the following:

☐ **Savings** OR ☐ **Checking**

Complete Name and Street Address of Financial Institution

City, State and Zip Code

Account Number

Routing Number

NOTE: PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP

V. Authorization to Reimburse Employer Directly

(this is for ongoing insurance premiums)

Signature

Date

Employer

Street Address of Employer

City, State, and Zip Code

Bank Account/Routing Number

Employer Authorization By

Title

VI. Signature

I agree that this claim represents qualifying medical expenses not covered/reimbursed by insurance and that I have separated from service with the employer sponsoring the plan. My signature below confirms my understanding and agreement with this requirement. I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable event by the IRS. ***PLEASE NOTE: On-going reimbursements will continue automatically until NRS is notified to stop the reimbursement.***

Signature of Participant

3/26/09

Date Signed