BENEFITS REFUND FORM

EMPLOYEE NAME: _____

EMPLOYEE ID: _____

BENEFIT PLAN CODE: _____

DEPARTMENT NAME: _____

PPE Date	Month/Year of Coverage	EE Medical Contribution	EE Comm Surcharge	EE UBH	ER Medical Contribution	ER Comm Surcharge	ER UBH
Benefit Refund Code			CEARDA	UEARUB		CSARDA	USARUB
TOTAL:							

Reason for Refund _____

ALL REQUESTS FOR TERMINATION OF COVERAGE MUST INCLUDE THE HEALTH INSURANCE TERMINATION REQUEST FORM.

Prepared By: _____ Phone: _____

Email Address: _____ Date: _____

DAS Use Only

Approved by: **Date:**

Keep a copy of this form for your records. Send the original to DAS/Benefits Administration Services.

Mail: DAS/Benefits Administration Services

30 E. Broad St., 28th Floor, Columbus, Ohio 43215

Fax: (614) 728-3002

Reset Form

Print Form

Health Benefit Refund Form Instructions

NOTE: If this refund is for a termination from state service, please include the signed Health Insurance Termination Request form. If the refund is due to the death of an employee, the agency should complete and sign the Termination Request form.

Benefit Plan Code: Fill in the plan code for which you are requesting the refund

OhioMed PPO -	A11015, A11025, A11050, A11100
UHC -	AC1015, AC1025, AC1050, AC 1100
AetnaPlan -	AD1015, AD1025, AD1050, AD1100
The Health Plan -	AK1015, AK1025, AK1050, AK1100
Paramount-	JM1015, JM 1025, JM1050, JM1100
	15 = 15%; 25 = 25%; 50 = 50%; 100 = 100%

	(employee code)	*(employer code)*
OhioMed PPO -	HEARMM	HSARMM
UHC -	HEARUH	HSARUH
AetnaPlan -	HEARAE	HSARAE
The Health Plan -	HEARHP	HSARHP
Paramount-	HEARPA	HSARPA

PPE Date: Pay period ending date **(You may request up to 2 months per form)**

Month/Year of Coverage: Fill in the month and year of coverage for which you are requesting the refund.

EE Medical Deduction: Fill in the amount of the Employee's medical deduction (excluding UBH & Communications surcharges).

EE Comm Surcharge: Fill in the amount of the Employee's Communications surcharge deduction.

EE UBH Surcharge: Fill in the amount of the Employee's UBH surcharge.

ER Medical Contribution: Fill in the amount of the Employer's contribution. (excluding the UBH & Communication surcharges).

ER Comm Surcharge: Fill in the amount of the Employer's Communications surcharge contribution.

ER UBH Surcharge: Fill in the amount of the Employer's UBH surcharge.

Reason: Indicate reason for the request.

Signature: Sign and date the form. Write in your phone number and email address.

Health Insurance Termination Request

Health insurance coverage will continue until the last day of the month for which a premium has been fully deducted. This may be the month **following** the last day of employment, providing deductions have been made for both pay periods in that month. Health care coverage for dependents will end when the employee's coverage ends. Additional coverage may be waived by completing the information below.

Please terminate health insurance coverage as of the last day of the month written below: .

_____200____.
(month) *(year)*

Coverage is being waived for the month of : _____200____.
(month) *(year)*

A refund for health insurance premiums that have been deducted is requested.

_____ _____

Employee ID# **Employee name**

_____ _____

Employee signature* **Date**

*If the refund is due to the death of an employee, the agency should complete and sign this form.