

 You may be able to submit and track the status of your reimbursement request online! Log in to your account at nrsforu.com and click "Manage Account" to locate "Request reimbursement" or "Track withdrawal status."

Information

A Post Employment Health Plan (PEHP) account is a benefit that has been established for you, your spouse, and/or your qualified dependents, by your employer when you separate from service. Your PEHP account can be used to provide for reimbursement of qualified post employment expenses for medical care, including expenses for medical insurance.

If you have an account for qualifying medical care expenses, your account will be automatically paid out when you submit a claim for the following approvable medical expenses:

- Health care premiums;
- Routine physical examinations;
- Prescription drugs.
- Medical co-pay or deductibles that are your responsibility, but are not reimbursed by your insurance plan;
- Dental care, including routine dental check-ups with orthodontia, and dentures;
- Hearing care, including examinations and hearing aids;
- Eye care, including examinations, glasses and contact lenses;

For more detailed information regarding qualified medical expenses, refer to Publication 502 and 969, available on the Internal Revenue Service website at www.irs.gov.

NOTE: Please submit itemized invoices of paid medical expenses with your claim. Itemized invoices provided must include proof of payment.

If you have an account for health care insurance premiums, your account will be automatically paid out when you submit a claim for the following approvable post-employment insurance expenses:

- Health care premiums
- Medicare premiums (subject to plan guidelines)
- Medicare Supplemental Insurance Premiums (Medi-Gap)
- Health care premiums - provided under your employer's COBRA benefits
- Prescription drug policy premiums
- Eye care policy premiums
- Dental care policy premiums
- Long-term health care premium expense

NOTE: Please provide proof of policy type, amount, and period.

If this is an adjustment to an existing claim you will need to include an updated policy showing the new amount for each premium being requested.

You must complete Section 5 if you prefer to be reimbursed directly to your bank account.

You must complete Section 6 if you prefer to have your former employer reimbursed directly for insurance premiums they pay on your behalf.

1. Employer Information

Employer Name: _____ Employer Number: _____

2. Dependent Information

Name: _____ SSN/TIN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Preferred Phone¹: _____ ☐ Home ☐ Work ☐ Cell

Email: _____

¹ Nationwide strives to provide excellent customer service to our Members. By providing your telephone number, you authorize Nationwide to contact you via telephone using automated technology to assist you with your account.

3. Participant Information

Name: _____ Account Number or SSN: _____

Date of Death: _____

Can you include a Death Certificate listing a cause of death if one is not already on file: ☐ Yes ☐ No ☐ Already on File

4. Reimbursement Direction (all fields REQUIRED)

NOTE: Please attach proof of policy type, amount, and period of paid medical expenses/proof of paid premium expenses (i.e. medical bills, prescription receipts, health insurance statements)

- ☐ **Request a New Reimbursement** (complete the rest of the document)
- ☐ **Cancel my Pending or Existing Reimbursement** (proceed to Section 8, sign and return the document)
- ☐ **Stop Systematic/Recurring Payment**
- ☐ **Change Systematic/Recurring Payment**

Reimbursement is for: ☐ Self ☐ Spouse ☐ Dependent(s)

Reimbursement amount: \$ _____ Systematic/Recurring Start Date: _____

Type of Reimbursement: ☐ One-time ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

NOTES: Insurance premium payment will default to one-time if a frequency is not selected. Any new ongoing insurance premium request will cancel any current ongoing PEHP systematic/recurring withdrawals.

5. Spouse/Dependent Information

1. Spouse/Dependent Name: _____ Date of Birth: _____
Relationship: _____
2. Dependent Name: _____ Date of Birth: _____
Relationship: _____
3. Dependent Name: _____ Date of Birth: _____
Relationship: _____
4. Dependent Name: _____ Date of Birth: _____
Relationship: _____

NOTE: for additional dependents, please attach information on a separate page with the Name, Date of Birth, and Relationship of each dependent. An IRS Form 1040 from the most recent filing tax year is required to update child dependents on file for those 27 year of age and older.

6. Payment Method

Select One:

- ☐ ACH Instructions on File – Send funds to my bank account that Nationwide has on file.
- ☐ Send check by first class mail to my address of record. Allow 5 to 10 business days from process date for delivery. (Default option, if no other option is selected)
- ☐ Direct Deposit ACH (complete information below)

Financial Institution Information:

Bank Name _____

ABA (routing) Number _____

Account Number _____

Account Type: ☐ Checking ☐ Savings

NOTE: If left blank, we will default to checking.

John Doe
123 Main Street Ph. (916) 555-1212
Hometown, CA 98765

1492

Date _____

PAY TO THE ORDER OF _____ \$ _____

_____ DOLLARS

Money Bank, Inc.
321 Main Street
Hometown, CA 98765

MEMO _____

1 123456789 1 000012345678 1 1492

9-digit ABA routing number Checking Account Number Check Number

Continued on nex page.

6. Payment Method (continued)

NOTE: We cannot accept a deposit slip or starter check for banking numbers.

Is this account associated with a brokerage firm or other investment firm? ☐ Yes ☐ No

If yes, have you confirmed that the ABA and account numbers are correct? ☐ Yes ☐ No

I hereby authorize Nationwide to initiate automatic deposits to my account at the financial institution named above. In the event an error is made, I authorize Nationwide to make a corrective reversal from this account. Further, I agree not to hold Nationwide responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account. This agreement will remain in effect until Nationwide receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit authorization form to Nationwide. In the event this direct deposit authorization form is incomplete or contains incorrect information, I understand a check will be issued to my address of record.

7. Authorization to Reimburse Employer Directly (this is for ongoing insurance premiums)

Routing Number: _____ Account Number: _____

Employer Mailing Address: _____

City: _____ State: _____ Zip: _____

Authorized Representative Signature: _____

Position/Title: _____ Date: _____

8. Signature

I agree that this claim represents qualifying medical expenses not covered/reimbursed by insurance and that the original account holder has 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.

Participant or Claimant:

Signature: _____ Date Signed: _____

Submission Instructions

Mail your completed form and supporting documents to:

Nationwide Retirement Solutions
PO Box 182797
Columbus, Ohio 43218

Email: rpublic@nationwide.com

Fax: 877-677-4329

Questions?

Service Center: 877-677-3678