



APPLICATION FOR REIMBURSEMENT OF HEALTH INSURANCE PREMIUM FOR MEMBERS AGE 65 OR OVER

DENVER EMPLOYEES RETIREMENT PLAN
777 Pearl Street
Denver, Colorado 80203-3717
Phone: (303) 839-5419 Fax: (303) 839-9525
e-mail: mbrsvs@derp.org

PLEASE PRINT OR TYPE

Name: _____ File Number: _____
(First Name, Middle Initial, Last Name)

Home Address: _____
(Street, Avenue, Road, P.O. Box, etc.)

(City, State, ZIP)

Telephone Number: _____ SSN (last four digits): _____
(Area Code, Number)

I am a member of Denver Employees Retirement Plan who is currently enrolled in an individual plan with Rocky Mountain HMO or SecureHorizons and my current physician or medical group will not accept the Anthem SmartValue PFFS plan. I hereby apply to participate in the Health Insurance Premium Reimbursement beginning _____1, 20____. I understand this benefit is to help pay for health insurance for me/my spouse/my dependents. The reimbursement will be the lesser of my health insurance premium(s) paid, the premium paid for the Anthem health insurance plan, or the Health Insurance Premium Reduction benefit which is based on my years of service with the City and County of Denver/DHHA. I understand the benefit is only available for premiums I have actually paid and will terminate when my coverage stops or when my physician or medical group begins to accept the Anthem SmartValue PFFS plan. I understand the reimbursement will stop upon the renewal date unless I complete a new application and affidavit.

- I authorize the Plan to automatically deposit the reimbursement to my account as indicated below (must be the same as the direct deposit of your retirement benefit):
(Attach a voided check for a checking account or a deposit slip for a savings account below)

FINANCIAL INSTITUTION	CHECK ONE
TRANSIT ROUTING NUMBER AND ACCOUNT NUMBER <i>(Lower Left Corner of Check)</i>	<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS

I also authorize the Denver Employees Retirement Plan, if necessary, to make adjustments to the above account to correct any credit entries made in error. I understand that the Denver Employees Retirement Plan will make a reasonable effort to notify me when an adjustment is made.

Member Signature: _____ Date: _____

The Plan may, upon notice, terminate, discontinue, or reduce the health benefit.