



APPLICATION FOR REIMBURSEMENT OF HEALTH INSURANCE PREMIUM FOR MEMBERS UNDER AGE 65

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

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

(City, State, ZIP)

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

I am a member of Denver Employees Retirement Plan who either resides outside the state of Colorado or resides in Colorado but outside of the service areas covered by the in-network group health insurance carriers. I hereby apply to participate in the Health Insurance Premium Reimbursement Program beginning 1, 20. I understand this benefit is to help pay for health insurance for me/my spouse/my dependents who are under the age of 65. The reimbursement will be the lesser of the health insurance premium(s) paid 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 I return to a service area covered by the in-network group health insurance carriers in Colorado or I reach age 65. I understand the reimbursement will stop upon the renewal date unless I complete a new affidavit.

DIRECT DEPOSIT IS REQUIRED.

- I authorize the Plan to automatically deposit the reimbursement to my account as indicated below. This must be the same account used for the direct deposit of your retirement benefit. (Attach a voided check or a letter from the banking institution indicating the routing and account numbers.)

Table with 2 columns: FINANCIAL INSTITUTION, CHECK ONE. Row 1: TRANSIT ROUTING NUMBER -and- ACCOUNT NUMBER (Lower Left Corner of Check), CHECKING, 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: