ARUP Continual Reimbursement Form For Alternate Qualified Group Health Plan Premium Differences

1 Employee Personal Information

ARUP
Company Name

Employee Email Address

Employee Name

Employee Social Security Number ***(Required)***

Employee Street Address | City | State | Zip Code

☐ Full Time ☐ Part Time
Employee Status

2 Spousal Plan Premium Information

Level of Coverage: ☐ Employee + Spouse ☐ Employee only ☐ Employee + 1 Dependent ☐ Employee + Children ☐ Spouse ☐ Spouse + 1 Dependent ☐ Spouse + Children ☐ Family

Monthly Premium Amount $_____ Coverage Start Date: _____ End Date: _____

Is the premium paid: ☐ Post-tax ☐ Pre-tax *(if the premium contributions are pre-taxed they will be considered taxable income and taxed by ARUP through payroll)*

3 ARUP Group Medical Premium Equivalents 2024

Reimbursement Cap *(per month)*	Coverage	Full-time Rate *(per month)*	Part-time Rate *(per month)*
$250	Employee Only	$110.00	$154.00
$250	Spouse	$110.00	$154.00
$500	Employee + Spouse	$195.00	$281.00
$500	Employee + 1 child	$195.00	$281.00
$500	Spouse + 1 child	$195.00	$281.00
$750	Employee + children	$270.00	$400.00
$750	Spouse + children	$270.00	$400.00
$750	Employee + family	$270.00	$400.00

Premium Difference calculation = (Alternate Qualified Health Plan premium (A) – ARUP Group Medical premium equivalent (B))

A _____ **- B** _____ **=** _____ *(must be greater than zero)*

4 Continual Reimbursement

Documentation must be provided on an annual basis to verify premium amount and coverage level. Reimbursement under the plan will not be made prior to the coverage period of the policy. Employee is not allowed to participate or receive reimbursement if the Employer or Employee is contributing to a HSA or HRA Plan.

Documentation must be submitted to NBS as follows:

- **Fax: 1-844-438-1496**
- **Email: Service@NBSbenefits.com**

No reimbursement may be paid under the continual reimbursement program for any month in which premiums are not paid. It is your responsibility to advise the plan administrator of the cessation or interruption of such premiums. Reimbursements will be issued on the **1st** and the **15th** of every month *(or the closest business day following these dates)*. **Proof of premium payments *(receipts)* must be sent to NBS on an annual basis.**

5 Employee Signature

I have reviewed the information on this request form and verify that the information listed above and attached is true and correct. I understand that if any changes regarding my Group Health Plan occur, I must notify ARUP within 30 days or I may face disciplinary action from ARUP or penalties from the IRS. NBS must also be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible. **I also understand that copies of receipts for payment of premiums must be provided annually or continual reimbursement will cease.**

Employee Signature

Date

P.O. Box 6980 West Jordan, UT 84084 • (855) 399-3035 • Fax (844) 438-1496 • my.nbsbenefits.com