Sacramento City Unified School District
Recurring Claim Authorization Form

Retiree Information

Last Name, First Name	SSN
Employer Name	**Email Address**
Sacramento City Unified School District	

Recurring Claim Information

Type of Service	For Whom	Plan Year	Monthly Premium Amount

Premium Substantiation: Attaching substantiation of your premium(s) with this form is required. Valid documentation may be an Insurance Premium Statement, a bank statement, a credit/debit card statement, and/or a letter from the Social Security Administration. Documentation must include the participant's name, coverage type or insurance company name, and premium amount.

Participant Authorization

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my Retiree Health Reimbursement Arrangement (HRA) and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA which relate to such expense. I am claiming health care reimbursement for eligible medical care expenses incurred by myself during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for my reimbursement of a non-qualifying expense. This authority will remain in full force and effect until Navia Benefit Solutions has received written notification from me of its termination in such time and in such manner as to afford Navia Benefit Solutions and the banking institution a reasonable opportunity to act on it.

❑ I authorize Navia Benefit Solutions to automatically reimburse me for the above health insurance premiums.

Signature	**Date**
X	

INSTRUCTIONS FOR COMPLETING THIS FORM

Accountholder/Participant Information

Retiree Last Name, First Name: Enter the last name and first name of the Retiree*

Retiree SSN: Enter the Retiree's social security number. Use last 4 digits of your SSN if e- mailing this form.

Employer Name: Please enter the Employer/Plan Sponsor name

Email Address: Please enter your email address to receive important account notifications electronically.

Premium Information for Recurring Claim Authorization – PREMIUMS ONLY

If already set up for recurring premium reimbursement and filling out this form to make changes to your existing monthly reimbursement, please also include the expenses you would like to continue being reimbursed for so that Navia can accurately calculate your new monthly reimbursement total.

Type of Service: Indicate the type of policy you are requesting monthly reimbursement for, such as "Medicare Supplement" or "Medicare"

For Whom: Indicate the name of the person who the policy is for.

Plan Year: Indicate the plan year dates.

Monthly Premium Amount: Enter the monthly premium.

Participant Authorization

Read the Agreement and mark the authorization box

Sign and Date the Agreement

FORM SUBMITTAL

Attach any necessary premium substantiation to this form and submit to Navia Benefit Solutions via:

E-mail 105@naviabenefits.com

Mail P.O. Box 5179, Fresno, CA 93755

Fax 1-866-831-6222

Direct Deposit Request Form

Instructions

1. Please write legibly to ensure proper processing.
2. Be sure to sign the form and submit! Please fax, email or mail a signed claim form, but choose one method only.

   Fax: (425) 233-6366 or toll-free (866) 535-9227

   Email: election@naviabenefits.com

   Mail: Navia Benefit Solutions, PO Box 53250 Bellevue, WA 98015-3250

Did you know you can enter direct deposit information online?
No paperwork necessary!

Employee Information

Last Name, First Name	**SSN / Employee ID #**
Home Address (Street, City, State, Zip Code) ☐ Please update my address on file	**Phone Number**
Employer Name	**Email Address -** required to issue debit card

Direct Deposit Request

Reimbursements are electronically deposited into your bank account. If you've previously signed up for direct deposit with Navia your information will remain on file and you do not need to complete this section.	❑ Yes	❑ Checking	Routing # _____
	❑ No	❑ Savings	Account # _____

- All direct deposits will be initiated according to your employer's reimbursement schedule. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information are assessed a $10.00 fee.

❑ **YES**, I authorize Navia Benefit Solutions to electronically deposit my reimbursements into the above specified bank account. This authority will remain in full force and effect until Navia Benefit Solutions has received written notification from me of its termination in such time and in such manner as to afford Navia Benefit Solutions and the banking institution a reasonable opportunity to act on it.

X _____ _____

Employee Signature **Date**

Need help filling out your form? Call Customer Service at (425) 452-3421 or toll free (866) 897-1996.