



P. O. Box 4346, Missoula, MT 59806

PREMIUM EXPENSE REIMBURSEMENT REQUEST

To send scanned claims, or for additional forms, go to:

www.allegianceflexadvantage.com

FAX: 406-523-3149 or, toll-free 877-424-3539 PHONE: 406-721-2222 or, toll-free 877-424-3570

Please print legibly in black or blue ink.

Employee Name: _____	Employer Name: _____
Employee ID: _____ (Social Security Number or, if assigned, alternate ID)	# Pages Submitted: _____
Return Phone Number: _____ - _____ - _____	Please call to confirm receipt? Yes <input type="checkbox"/>
Attention: _____	Comments: _____

<u>Premium</u>	<u>For the Month of</u>	<u>Amount Paid</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

YOU MUST SUBMIT INDEPENDENT, 3RD-PARTY DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. SEND A COPY OF A BILL OR INVOICE IDENTIFYING THE CURRENT PREMIUM AND THAT IT HAS BEEN PAID. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.

I certify that these statements are true and that the claimed expenses cover only myself, my tax dependents, and/or spouse (if filing federal taxes jointly). I further understand that premium expenses reimbursed may not be claimed on my individual tax return.

Signature (required): _____ Date: _____

Check here if your address has changed. New address: _____
