

Retiree Reimbursement Account (RRA) Claim Form

Mail or Fax completed form and documentation to:
 Inspira Financial
 PO Box 2495
 Omaha, NE 68103
 Fax: 888-238-3539
 Page 1 of _____
 For Customer Service: 888-678-8242 (TTY: 711)

**To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.
 WAIT! Did you know that you can file a claim online or by using the Inspira Mobile® app?**

To get started, log in to the mobile app or your member website: inspirafinancial.com. You can also find instructions online for completing this form.

Member Identification Number (Employer/Member assigned number or W ID)	Member Full Name (Last Name, First, MI)
Member Address (Street, City, State, ZIP Code)	

Note: If you have an address change, please notify your former employer. For security purposes, we can only accept an address change from your former employer.

Employer Name Owens Corning

Health Care Expenses

Patient Name	Type of Service (deductible, dental, medical, vision)	From Date of Service (not payment date) MM/DD/YYYY	To/Thru Date of Service (not payment date) MM/DD/YYYY	Amount Requested
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
Total				\$

****If more lines are needed, please complete another form.**

Insurance Premium Expenses

NOTE: For Medicare premiums (deducted from your Social Security check): If this is the first time this calendar year you are requesting reimbursement of premiums, enclose a copy of your "Notice of Medical Insurance Enrollment and Premium Deduction." This is from the Department of Health and Human Services (HHS). After that, you only have to complete this claim form. **Note:** Premiums that you pay pre-tax are not eligible expenses. If this is a request for other insurance premium expenses, enclose a copy of the appropriate supporting documentation.

Covered Eligible Person's Name	Type of Service (Premium)	Type of Premium (Medicare, Medigap, Medical, Dental, etc.)	Annual Social Security Administration Letter If previously submitted, please check Yes	From Date of Service MM/DD/YYYY	To/Thru Date of Service MM/DD/YYYY	Amount Requested
			<input type="checkbox"/> Yes			\$
			<input type="checkbox"/> Yes			\$
			<input type="checkbox"/> Yes			\$
			<input type="checkbox"/> Yes			\$
			<input type="checkbox"/> Yes			\$
Total						\$

****If more lines are needed, please complete another form.**

I certify that I, have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. If the expense is for insurance premium, I understand that this does not include premiums paid with pre-tax salary reduction. (Premium that is paid pre-tax is not an eligible expense.) I understand that "incurred" means that the service has been provided. This is regardless of when I am billed, charged for or pay for the service. I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed materials for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

I understand that state laws may prohibit the reimbursement of certain expenses and I certify this reimbursement claim and any related documentation provided complies with my state's law regarding the reimbursement of expenses for certain services.

Member Signature 	Date
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****If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.****