

**EMPLOYEE INSURANCE PROGRAM  
FINANCIAL SERVICES UNIT  
REFUND REQUEST**

AGENCY NUMBER \_\_\_\_\_ AGENCY PROCESSOR \_\_\_\_\_ TELEPHONE # \_\_\_\_\_ DATE SENT \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ BIN \_\_\_\_\_ MONTHLY BILL COVERAGE CHANGE APPEARS\* \_\_\_\_\_

REASON FOR OVERPAYMENT \_\_\_\_\_ TOTAL AMOUNT DUE \_\_\_\_\_

| Date of Deduction | HEALTH               |                 | DENTAL           |                 | DENTAL PLUS      |                 | OPTIONAL LIFE     |                 | DEPENDENT LIFE SPOUSE   |                 |
|-------------------|----------------------|-----------------|------------------|-----------------|------------------|-----------------|-------------------|-----------------|---|-----------------|
|                   | DEDUCTION AMOUNT     | CORRECT PREMIUM | DEDUCTION AMOUNT | CORRECT PREMIUM | DEDUCTION AMOUNT | CORRECT PREMIUM | DEDUCTION AMOUNT  | CORRECT PREMIUM | DEDUCTION AMOUNT  | CORRECT PREMIUM |
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|                   | Subtotal:            |                 | Subtotal:        |                 | Subtotal:        |                 | Subtotal:         |                 | Subtotal:   |                 |
| Date of Deduction | DEPENDENT LIFE CHILD |                 | SUPPLEMENTAL LTD |                 | VISION           |                 | TOBACCO SURCHARGE |                 | <p><b>*If the overpayment is due to a coverage change, do not submit the refund request until the change has appeared on the bill and/or the payroll deduction has been corrected or stopped.</b></p> |                 |
|                   | DEDUCTION AMOUNT     | CORRECT PREMIUM | DEDUCTION AMOUNT | CORRECT PREMIUM | DEDUCTION AMOUNT | CORRECT PREMIUM | DEDUCTION AMOUNT  | CORRECT PREMIUM |   |                 |
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|                   | Subtotal:            |                 | Subtotal:        |                 | Subtotal:        |                 | Subtotal:         |                 |   |                 |