Preparing People to Lead Extraordinary Lives

LOYOLA UNIVERSITY CHICAGO

Benefit Express
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Arlington Heights, Il 60006
877-837-5017
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Benefit Express

Loyola Retiree Health Benefit Reimbursement Request Form

Reimbursement Information

Total Amount of Reimbursement Requested $ _____

_____

Participant's Signature Date

I certify that the expenses listed on this request have been paid on an after tax basis.

Participant Information

Social Security Number: _____

Name: _____
(First Name) (Middle Initial) (Last Name)

Current Address _____
(Street Address) (Apt No.)

☐ _____
(City) (State) (Zip)

Check Here If New Address _____
(Phone Number)

Reimbursement Requested

Date Services Were Provided Insert the date services were actually rendered and not the payment date	**Name of Provider of Service** Insert the name of the entity the premium was paid to (i.e. Medicare, Insurance Company Name, Pharmacy ,etc)	**Amount** (Print amount of reimbursement requested)

In order to receive reimbursement, supporting documentation must be attached to this completed request form.