IB10
Revised 08/12

SEIB OFFICE USE ONLY OK TO REFUND	
Mo/Day/Year	By

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8341 / FAX: 334.517.9728

REFUND REQUEST

A refund of State Employees' Health Insurance premiums is requested for the department and/or employee referenced below:

Agency Identification Data

Agency name_____

Agency No. _____

Flex Plan: Yes_____ No_____

Employee Identification Data

Employee name_____

Address:_____

City: _____State: ____ ZIP: _____

Social Security #_____

Refund amount $_____ Coverage Period: _____ through _____

Reason for requesting refund of premiums (check the appropriate line):

____ Employee terminated: Date_____

____ Employee retired: Date_____

____ Employee began leave without pay: Date_____

____ Employee notified SEIB on _____ to drop coverage on _____Employee ____ Dependent

Effective date_____ (attach change form)

____ Dependent died: Date_____

____ Employee died: Date_____

____ Coverage was paid/deducted in error on _____Employee _____Dependent

for the period of _____ through _____

____ Employee status changes to ____full time ____part-time: Date _____

____ Other reason. Please explain_____

_____

_____
Signature of Official requesting refund