Nationwide® Retirement Solutions
On Your Side™

PEHP CLAIM FORM

A Post Employment Health Plan (PEHP) account is a benefit that has been established for you, your spouse, and/or your qualified dependents, by your employer when you separate from service. Your PEHP account will be used to provide for reimbursement of qualified post employment expenses for medical care, including expenses for medical insurance, which are incurred during post-employment period.

If you have a Universal Medical Expenses Account (05), your account will be automatically paid out when you submit a claim for the following approvable medical expenses:

- Medical co-pay or deductibles which are your responsibility are not reimbursed by insurance;
- Health care premiums;
- Eye care, including examinations, glasses and contact lenses;
- Routine physical examinations;
- Dental care, including routine dental check-ups with orthodontia, and dentures;
- Hearing care, including examinations and hearing aids;
- Prescription drugs.

For more detailed information regarding qualified medical expenses, visit the Internal Revenue Service website at www.irs.gov.

NOTE: IN ORDER FOR YOUR CLAIM TO BE PAID OUT, YOU MUST ATTACH RECEIPTS OF PAID MEDICAL EXPENSES.

If you have a Insurance Premiums Only Account (06), your account will be automatically paid out when you submit a claim for the following approvable post-employment insurance expenses:

- Health care premiums
- Medicare premiums (subject to plan guidelines)
- Medicare Supplemental Insurance Premiums (Medi-Gap)
- Eye care policy premiums
- Dental care policy premiums
- Prescription drug policy premiums
- Health care premiums - provided under your employer's COBRA benefits
- Long-term health care premium expense

NOTE: IN ORDER FOR YOUR CLAIM TO BE PAID OUT, YOU MUST ATTACH PROOF OF PAID PREMIUM EXPENSES.

You must complete Section III if you prefer to be reimbursed directly to your bank account.

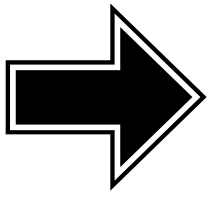
You must complete Section V if you prefer to have your former employer reimbursed directly for insurance premiums they pay on your behalf.

Mail your completed form and supporting documents to:

Nationwide Retirement Solutions
P.O. Box 182797
Columbus, Ohio 43218

Service Center: 1-877-677-3678

Complete form on the reverse page



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PEHP CLAIM FORM

I. Personal Information

Name (Please Print) _____ Social Security Number _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Work Telephone Number _____ Employer Name/Plan Number *(if applicable)* _____

Email Address _____

II. Reimbursement

NOTE: Please Attach Receipts of paid medical expenses/proof of paid premium expenses (i.e. medical bills, prescription receipts, health insurance statements)

Reimbursement Is For: ☐ **Self** ☐ **Spouse** ☐ **Dependent***

**** If Reimbursement is for Dependent: (for multiple dependents please attach on a separate page)***

Spouse/Dependent Name_____ **Date of Birth**_____

Relationship_____

Reimbursement Amount: $_____ ☐ **One-time** ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

If applicable, would you like to continue your current payout? ☐ **YES** ☐ **NO**

III. Severence of Employment Verification

This section must be completed by your Payroll Department, only if this is an initial payout request.

_____

Signature of Certifying Official ***Separation from Service Date***

IV. Automated Deposit Authorization

I hereby authorize my PEHP plan provider, hereinafter called COMPANY, to initiate credit entries to my account indicated below in the financial institution named below. I specifically agree to hold harmless and not seek recovery against the COMPANY, its officers, directors, employees and agents for any loss which I may sustain due to the actions or inactions of my designated financial institution or the information contained in this form. The credit entries will represent payments due to me under the Post Employment Health Plan. This program will begin within 30-45 days after receipt of this notification, after which all payments will be made to my account within **3 business days** following the withdrawal. By signing this form, I agree to direct my executors, administrators, or assignees to refund any payments which are made for any period following my death so they may be redistributed to my beneficiary if applicable. Note: Your financial institution must be a member of the Automatic Clearing House (ACH). Call your financial institution if you are unsure.

For deposits to your financial institution, please complete the following: ☐ **Savings OR** ☐ **Checking**

Complete Name and Street Address of Financial Institution _____ **City, State and Zip Code** _____

Account Number _____ **Routing Number** _____

NOTE: Please Attach a Voided Check or Deposit Slip

V. Authorization to Reimburse Employer & Insurer Directly *(this is for ongoing insurance premiums)*

Signature _____ **Date** _____ **Employer** _____

Street Address of Employer _____ **City, State, and Zip Code** _____ **Bank Account/Routing Number** _____

Employer Authorization By _____ **Title** _____

VI. Signature

I agree that this claim represents qualifying medical expenses not covered/reimbursed by insurance and that I have separated from service with the employer sponsoring the plan. My signature below confirms my understanding and agreement with this requirement. I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable event by the IRS.

Signature of Participant _____ Date Signed _____