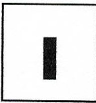

CLAIM FORM FOR PERSONAL BENEFIT INSURANCE PREMIUM DISBURSEMENT

Effective 1/1/2005

1. NAME & ADDRESS: ____

   ____

   ____

2. HOME PHONE: ________________ SOCIAL SEC. #: XXX-XX-____________

3. TYPE OF INSURANCE (CHECK ONE):

   __ LONG TERM CARE
   __ UNIVERSAL LIFE
   __ OTHER ____

4. PAY TO CARRIER : ________________ PAY TO MEMBER: ______________

5. CARRIER'SNAME& ADDRESS: ______________________________________

   ____

   ____

6. INSURED NAME: ____

Section 14.6 Payment of Personal Benefit:
You are eligible to receive benefits from your Individual Account if one or more of the following apply…
"(e) You have an insurance premium payment for yourself or family member, including long term care, term life or Universal life. Benefits can be paid until your Individual Account Balance has been reduced to zero."…

Statement: I have read eligibility requirements for insurance premium reimbursement and hereby apply for payment. I understand that the distribution for this purpose is reportable to me as taxable compensation for both Federal and State purposes regardless of whether it is paid directly to myself or directly to the provider, and is subject to FICA/ Medicare, FUTA and NJ SUI, with a Form W-2 issued to me in January following year's end. I further understand that the taxable amount on the Form W-2 will be higher than the amount I have requested in order for FICA and Medicare taxes to be withheld. **(REV 1/1/2021)**

DATE: ____________________ PRINT NAME: ________________________

SS#: XXX-XX-______________ SIGNATURE: ________________________

OFFICE USE ONLY

Balance ______________ **Approved by** ______________

Billing Amount ______________ **Date** ______________

Policy Number ______________ **Check Number** ______________

Premium Period ______________

Comments ____