Recurring Reimbursement Agreement

Use this form to be reimbursed for prepayment of monthly premiums.

Instructions: Please complete this form and all required fields. Include a copy of your annual premium notice or first monthly invoice with proof of first month's payment. Return form and documentation to the address or fax number listed below. Once approved, reimbursement will be issued monthly through the remainder of the calendar year based on credits available in your Healthcare Reimbursement Account. You must complete and submit this form annually.

(Required) **Name of Retiree/Surviving Spouse:** _____

(Required) **Retiree/Surviving Spouse's 7-digit Employee ID:** _____

Employer: Illinois Tool Works

Plan Type: Healthcare Reimbursement Account

Account: Medical Account

Frequency: Monthly Reimbursement

Expense Category: Medical Expense

Expense Type: Medical Insurance

(Required) **Person for Whom Expense is Incurred:** _____

(Required) **Amount to be reimbursed per month:** $_____

Period over which premiums paid to be reimbursed:

(Required) **Reimbursement Month Start Date:** _____

(Required) **Reimbursement Month End Date:** _____

Claimant's Statement

I understand that this form is submitted to verify certain expenses incurred and paid by me for reimbursement under my employer's qualified Healthcare Reimbursement Account. I agree to notify Benefit Strategies immediately of any change or modification of any of the information contained herein including a change in my enrollment or reduction in expenses claimed to be paid by me. Failure to notify Benefit Strategies of a reduction in eligible recurring expenses may result in tax penalties.

(Required) **Retiree/Surviving Spouse Signature:** _____ ***(Required)*** **Date:**_____

Please return completed form and documentation to:

Benefit Strategies, LLC
P.O. Box 3970
Manchester, NH 03105-1300
Fax: 866-490-0319