IB10
Revised 08/08

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: 334.263.8541

REFUND REQUEST

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

Agency Identification Data | **Employee Identification Data**

Agency Name: ___________________ Employee Name: ______________________________

Agency No: ______________________ Address: _____________________________________
(If applicable) Street Number

City: ____ State: _____________ ZIP: __________________

CAS Fund: _______ Activity/Org: ___________ Appropriation: ___________

Flex Plan: ______ Yes ______ No 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