IB10
Revised 12/16

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

STATE EMPLOYEES' INSURANCE BOARD
PO BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334-263-8341 / FAX: 334-263-8541

REFUND REQUEST

A refund of State Employees' Health Insurance Plan 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 Number: _____

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