Reimbursement Form

OneExchange®
from Towers Watson

Mail: P.O. Box 981156, El Paso, TX 79998-1156

Fax: 1-844-930-0236

① Former Employer Name: Rockwell Collins

Total Pages:

Account Holder Name – Last:

First:

Middle:

Social Security Number: ___ - ___ - ____

Zip Code: _____

②

Date of Service MM/DD/YYYY	Type of Coverage	Covered Participant Name	Relationship e.g., Self	Amount Requested
01/01/2016	Medical	John Doe	Spouse	$XXX.XX
			Total Amount Requested	

③ By signing below, I certify that the information provided on this reimbursement form is correct and that the premiums for which I am requesting or for which I am providing validation: were incurred for premiums for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement.

Account Holder Signature

Date

④ To qualify for your reimbursement you must provide a third party document that includes the information to the right.

Please CHECK ☑ Each Reimbursement Qualification item as you complete them.

☑ **Does your document(s) include these items?**

- ☐ Covered Participant Name (e.g., John Doe)
- ☐ Provider Name (e.g., AARP)
- ☐ Date of Service (e.g., 01/01/2016)
- ☐ Description of Coverage (e.g., Medigap)
- ☐ Proof of Payment

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