

# TAXSAVER PLAN

## Retirement Medical Premium Reimbursement Claim Form – Alcatel USA

### Section I: Completing your reimbursement request

This form applies to you if you elected "independent", "other" or "deferred" coverage under your Alcatel Retirement Medical Plan. To complete this form:

- Fill in the requested information in this section about yourself and your spouse, if applicable
- Fill in other coverage information in Section II
- Complete the individual monthly premium information for you and your spouse in Section III
- Also in Section III, the total amount requested and the period for which reimbursement is applicable
- Attach the appropriate documentation, such as receipts, statements and payroll deductions stubs, Medicare statements, etc.
- Sign and date the form at the bottom. Keep a copy for your records and mail to the address below.

Retiree Name: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Retiree SSN: \_\_\_\_\_ Spouse SSN: \_\_\_\_\_

Retiree Home Phone & Email: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Section II: Other Coverage Information

Name of Insurance Carrier: \_\_\_\_\_

### Section III: Reimbursement Request

Total Premium for Period: \$ \_\_\_\_\_ \$ \_\_\_\_\_  
\$ \_\_\_\_\_ Premium Retiree Premium Spouse

Period of Coverage (month and year) \_\_\_\_\_

I hereby agree to reimburse Alcatel or its representative for any overpayment that is in excess of the amount payable under the medical plan. I hereby certify and swear under oath that the statements hereon are true, complete and accurate to the best of my knowledge and authorize my employer to cancel my medical coverage if I have misrepresented any material fact.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

### Filing for your Reimbursement:

You may submit for up to 3 months of premium payments in advance. The total amount of reimbursement shall not exceed the amount in your total account. To expedite your reimbursement, please use this form each time you file for reimbursement. You may photocopy this form if needed.

**Submit Expense To:** Taxsaver Plan  
P.O. Box 609002  
Dallas, Texas 75360  
800-328-4337 – [www.taxsaverplan.com](http://www.taxsaverplan.com)

214-528-8122 Fax  
[claims@taxsaverplan.com](mailto:claims@taxsaverplan.com) - attach tiff jpeg or jif files. (please do not scan at  
a high resolution)