Mail completed form to:
UMR
333 West Vine St, Suite 500
Lexington, KY 40507
Email: AMSpousalReimbursement@umr.com
Fax: 859-226-1191

ArcelorMittal

Reimbursement of Spouse Premium

1. This form is to be used to submit a claim for reimbursement of premiums paid by your spouse for health care coverage. You may file for reimbursement as often as once a month. **Requests for reimbursement must be submitted no later than thirty-six (36) months after date of payment.** Reimbursements will be made payable to the ArcelorMittal USA employee.

2. Form Instructions:
   a. Complete Employee's statement; and
   b. Spouse to complete Spouse's statement

3. Provide proof of premium payments by either:
   a. Having your Spouse's employer complete the reverse side of this form; <u>OR</u>
   b. Provide equivalent proof, such as check stubs showing premium deductions, cancelled checks or money orders and associated invoices, or a signed letter from the spouse's employer's plan

EMPLOYEE'S/RETIREE'S STATEMENT

I certify this claim for reimbursement is within the provisions of the Spousal Reimbursement Plan.

Employee/Retiree Name________________________________

Date of Birth ________________________________

Address________________ City____________ State______ Zip______

Spouse's Name________________________

Claim for Date: Beginning (From) ________________ Ending (To) ________________

Total Amount of Premium Paid During the Above Period________________________

Spouse's Employer Name________________________________

Spouse's Employer Address________________________ City____________

State____________ Zip____________

Employee's/Retiree's Signature________________________________

Date____________________ Home/Cell Phone No. (_____)________________

SPOUSE'S EMPLOYER'S STATEMENT

Completing this section is just one of the options for providing proof of premiums paid. Other options are available (see 3.b. on Side One of this form)

I hereby authorize my employer to release the information requested on this form.

______________________________ ______________

Spouse Signature: Date:

The ArcelorMittal USA benefit plan allows for a reimbursement of premiums paid by your employee their health care coverage or coverage for their children only. Any additional premium paid to cover your employee's spouse (beyond the amount required to cover your employee and their children) should not be included on this form.

In order to verify eligibility for reimbursement, the following information must be completed:

Employer ______________________________

Employee Name ______________________________

Effective Date of Insurance ______________

Effective Termination Date of Insurance ______________ (If Applicable)

Premium Deduction or Payment Frequency

☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Yearly

Do you offer Coverage for	Employee Enrolled Yes/No	Type of Coverage <Employee Only <Employee & Children	Premium Paid Per Deduction or Payment
Medical			
Rx			
Dental			
Vision			

Name ______________________ Title ______________

Address ______________ City ________ State ________ Zip ________

Signature ______________ Date ________ Phone No. (   ) ________

For Administrator Use Only

Period Req ____________ Through ____________

____________ X ____________ = ____________

No. of Mos. Monthly Premium

Amount to be Reimbursed