

Employee: Current Year Request For Refund Form
RMD Current Year Refund Request Form (Employee)

Date: _____

From: _____ Phone: _____
 Human Resources Representative or Payroll Officer

_____ State Agency

_____ State Agency Address

_____ Employee ID _____ Employee Name _____ Agency Code

Please select the benefit option to be refunded:

<input type="checkbox"/>	Administrative Fee	<input type="checkbox"/>	Disability
<input type="checkbox"/>	Presbyterian	<input type="checkbox"/>	Supplemental Life-Employee
<input type="checkbox"/>	Blue Cross Blue Shield	<input type="checkbox"/>	Dependent Life-Spouse/Domestic Partner
<input type="checkbox"/>	Cigna	<input type="checkbox"/>	Dependent Life-Child(ren)
<input type="checkbox"/>	Delta Dental	<input type="checkbox"/>	Flexible Spending Plan (FSA)
<input type="checkbox"/>	EyeMed	<input type="checkbox"/>	Other

Period: _____
 First Pay Period End Date (mm/dd/yyyy) Last Pay Period End Date (mm/dd/yyyy)

Employee Portion:

SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
SHARE HCM Code:		Amount:	
		Total Amount:	

In order for this request to be processed, a copy of the applicable payroll deduction screen and spreadsheet must be attached.

Brief Explanation of Refund Request:

EBB Approval: _____ Date: _____

Make Warrant Payable To: _____
 Employee Name

 Address

 City/State/Zip Code

FOR GSD/ASD USE ONLY: A copy should be sent to Erisa without attachment