**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:

| | | | |
|---|---|---|---|
| ☐ | Administrative Fee | ☐ | Disability |
| ☐ | Presbyterian | ☐ | Supplemental Life-Employee |
| ☐ | Blue Cross Blue Shield | ☐ | Dependent Life-Spouse/Domestic Partner |
| ☐ | Cigna | ☐ | Dependent Life-Child(ren) |
| ☐ | Delta Dental | ☐ | Flexible Spending Plan (FSA) |
| ☐ | EyeMed | ☐ | Other |

Period: _____ _____

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

Employee Portion:

| | | | |
|---|---|---|---|
| SHARE HCM Code: | | Amount: | |
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| SHARE HCM Code: | | Amount: | |
| | | **Total Amount:** | 0.00 |

***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*