Agency: *Prior Calendar Year* Request For Refund Form

Prior Calendar Year Request for Refund 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		Delta Dental
	Blue Cross Blue Shield		Vision Service Plan
	Lovelace		Flexible Spending Plan (FSA)
	Dependent Life		Additional (Supplemental) Life

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

Agency 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:	
		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 attachments rev Jan. 2015