Employee: *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	☐	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:	
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:	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