**CITY OF DETROIT POST-2014 NON-SAFETY EMPLOYEE**

**RETIREE HEALTHCARE TRUST**

**P.O. BOX 1497**

**TROY, MICHIGAN 48099-1497**

**(248) 641-4989**

**Health Reimbursement Account (HRA)**

**Humana Authorization Claim Form**

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| --- | --- |
| **Retiree’s Name:** | **Retiree’s SS# or Alternate ID:** |
| **Address:** | **City:** |
| **State:** | **Zip Code:** |
| **Phone Number (home):** | **Phone Number (cellular):** |
| **Email address:** |

Type of Service Providers Name Date of Service Amount of Claim

 **Medical Premium HUMANA 2021 $149.00**

**For questions regarding this form and the Humana Medical Premiums, please contact TMR & Associates at (313) 963-1135.**

By completing and submitting this form I authorize BeneSys to deduct my Humana monthly premium, which is $149, from my HRA account.

By signing this form, I understand that benefits shall be paid in accordance with the City of Detroit Post-2014 Non-Safety Employee Retiree Healthcare Trust.

Retiree’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_