DEPARTMENT OF FINANCE
CHICAGO BENEFITS OFFICE
UNCASHED RETIREE HEALTHCARE PREMIUM REFUNDS
(FOR RETIREE, RETIREE'S REPRESENTATIVE OR ESTATE)

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Information about Individual Seeking Refund

First Name: _____ Middle Initial: _____ Last Name: _____

Current Address: Number and Street Name _____ State ____ City _____ Zip-Code _____

Phone Number: _____

Information about Retiree

Name of Retiree (If different from above): First Name _____ Middle Initial _____ Last Name _____

Retiree's Most Recent Address (If different from above): Number and Street Name _____ State ____ City _____ Zip-Code _____

Last four digits of Retiree's Social Security Number: _____

	Check Date	$ Amount
Check(s) Issued (Information obtained from the search as directed in the Instructions)		

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Check the item that applies:

◯ I am the Retiree

◯ I am the legally authorized representative of the Retiree

◯ I am the legally appointed representative of the Estate of the Retiree

If not the Retiree, what is your relationship to the Retiree? _____

1. I, _____ (print name), declare, under penalty of perjury, that the City of Chicago issued the above-listed Retiree Healthcare Premium Refund check(s) to the above-listed Retiree, the check(s) was/were not cashed, and the City of Chicago has not reissued payment on the check(s); **OR**, if I am not the Retiree, I verified that the Retiree's name was listed after conducting a search on the City's webpage. The amount(s) identified above currently remain(s) unpaid.

2. I elect to (please select one of the following options):

   ☐ Request that the City of Chicago reissue the above-listed Premium Refund check(s) to me or to the correct payee (in the case of a legal representative or representative of an estate, who must follow the instructions provided below), at the address I provided above;

   OR

   ☐ Waive any right to the above-listed Premium Refund check(s).

3. I understand that the City may require me to provide further information and/or documentation to confirm that I am entitled to the above-listed uncashed refund checks(s) and I will reasonably cooperate with the City's requests in a timely manner.

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I certify under penalty of perjury that the foregoing is true and correct. I acknowledge that, under the Municipal Code of the City of Chicago, any person who knowingly makes a false statement of material fact to the city in connection with any application, report, affidavit, oath, or attestation, or when seeking a claim for payment from the City, is liable to the city for civil penalties, potential litigation and collection costs, and attorneys' fees. Municipal Code of Chicago sections 1-21-010(a) and 1-22-020(l).

_____ _____

Signature Date

_____

Print Name

Additional Information:

For Legally Authorized Representatives of a Retiree or a Retiree's Estate - In order to claim any potential Healthcare Premium Refund Check on behalf of a Retiree, you must demonstrate that you are legally authorized to accept such a refund. You will need to submit:

(1) the completed form;

(2) copies of the documentation establishing that you have legal authority to act on behalf of the Retiree, such as a Power of Attorney, a Small Estate Affidavit, an Order from Probate Court, or other Court Orders; **and**

(3) a copy of your State Driver's License or State-Issued Identification.

Mail Completed Affidavit and any Additional Information to:

Chicago Benefits Office - **ATTN: Reissue Project**
Department of Finance
333 South State Street
Room 400,
Chicago, Illinois 60604