



# OPERS Retiree Medical Account (RMA) Survivor Certification

Fax Completed Form to: 888-238-3539  
 You may also mail a completed form to:  
 Inspira Financial  
 PO Box 2495  
 Omaha, NE 68103  
 Telephone: 844-729-3539 (TTY:711)

If you are a survivor of the original RMA participant, you may complete this form so that you will be recognized as an Authorized Survivor.

As an Authorized Survivor, you will have access to the balance within the deceased RMA Participant's account. This means Inspira Financial can reimburse you from the RMA for any qualified medical expenses you may incur. You may also complete the Direct Deposit form to receive your reimbursements electronically into your bank account.

### Instructions

1. Complete sections A and B.
2. Sign the form.
3. Return it to Inspira Financial.

**Note:** Be sure the form is complete and signed. You may need to send additional documentation.

### Section A – Member Information (This section requests information about the original RMA participant.)

|  |                      |   |                      |
|--|----------------------|---|----------------------|
| Deceased Member Name (First, MI, Last) |                      | Last four digits of Member Social Security number |                      |
| <input type="text"/>                   |                      | XXX-XX- <input type="text"/>                      |                      |
| Address                                | City                 | State   | ZIP Code             |
| <input type="text"/>                   | <input type="text"/> | <input type="text"/>                              | <input type="text"/> |

### Section B – Survivor Information (This section is for the individual who wants to become the Authorized Survivor.)

|   |                                       |                                 |                      |
|---|---------------------------------------|---------------------------------|----------------------|
| Survivor Name   |                                       | Relationship to Deceased Member |                      |
| <input type="text"/>  |                                       | <input type="text"/>            |                      |
| Address   | City                                  | State                           | ZIP Code             |
| <input type="text"/>  | <input type="text"/>                  | <input type="text"/>            | <input type="text"/> |
| Daytime Telephone<br>( <input type="text"/> ) - <input type="text"/> - <input type="text"/> | Email Address<br><input type="text"/> |                                 |                      |

### Section E – Survivor Signature

I request and authorize Inspira Financial to recognize me as the eligible survivor for the deceased OPERS member named above. The information shown on this form is voluntary. I affirm that the information provided on this form is true and complete to the best of my knowledge and belief. I know there will be penalty for any false statement. I know failure to provide the requested information could prevent future RMA claim reimbursements. I know this survivorship expires at the time of my death or until I send a written request to OPERS to cancel it. When I sign this form, I'm certifying that I'm a qualified spouse or dependent under an OPERS healthcare plan.

|                      |                      |                      |
|----------------------|----------------------|----------------------|
| Print Name           | Signature            | Date                 |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

### Inspira Financial

Inspira Financial cannot and shall not provide any payment or service in violation of any United States (US) economic or trade sanctions.