south carolina peba SM
state health plan | retirement systems

Serving those who serve South Carolina

Refund request

Agency number_____ Agency processor_____ Phone no._____ Date sent_____

Subscriber name_____ SSN_____ Monthly bill coverage change appears*_____

Reason for overpayment_____ Total amount due_____

Date of deduction	HEALTH		DENTAL		DENTAL PLUS		OPTIONAL LIFE	
	Amount of deduction	Correct premium	Amount of deduction	Correct premium	Amount of deduction	Correct premium	Amount of deduction	Correct premium
	Subtotal:		Subtotal:		Subtotal:		Subtotal:	
	DEPENDENT LIFE SPOUSE		DEPENDENT LIFE CHILD		SUPPLEMENTAL LTD			
	Subtotal:		Subtotal:		Subtotal:			

Note: If overpayment is due to a coverage change, do not submit the refund request until the change has appeared on the bill and/or the payroll deduction has been corrected or stopped.