# LAFAYETTE COLLEGE
## MEDICAL INSURANCE PREMIUM REIMBURSEMENT FORM

For Use by Eligible Part-time Employees and Retirees

Complete and mail to the Office of Human Resources, 12 Markle Hall along with a copy of the premium bill for the reimbursement claimed. Premium bills must indicate the name of the subscriber, the amount of premium paid and the time period for which you were billed.

**PERIOD:**

- ☐ January - March
- ☐ April - June
- ☐ July - September
- ☐ October - December

**DEPENDENTS COVERED:** ☐ Wife ☐ Husband ☐ Children

**PREMIUMS PAID:** Name of plan _____

Policy number _____

Amount paid _____

**REIMBURSEMENT REQUESTED:** _____

This is to certify that I have been enrolled in the above programs which provide basic hospitalization, medical/surgical coverage for the three-month period indicated, and that I have paid the premiums as stated above.

Date_____ Signature_____