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
☐ ___February
☐ ___March

☐ ___April
☐ ___May
☐ ___June

☐ ___July
☐ ___August
☐ ___September

☐ ___October
☐ ___November
☐ ___December

HR Office use only:

NAME:
INDEX:
L#
MONTH:
AMOUNT:
APPROVAL:
DATE:

PREMIUMS PAID:
PLAN NAME:____________________________
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: __________________________
Print Name: _______________________
Signature: _______________________