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: _____