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

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: ________________________