LAFAYETTE COLLEGE
MEDICAL INSURANCE PREMIUM REIMBURSEMENT FORM

Complete and email, fax or scan to the Office of Human Resources along with a copy of the premium bills 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.

Reimbursement requested for:

____**January**
____**February**
____**March**
____**April**
____**May**
____**June**
____**July**
____**August**
____**September**
____**October**
____**November**
____**December**

HR Office use:

NAME:

INDEX: 9245

L#:

MONTH:

AMOUNT:

APPROVAL:

DATE:

ITEMIZATION OF PREMIUM COSTS* (only one month itemization and proof for each person required unless amounts change: please attach proof for each monthly amount)

Insurance Plan Name	Policy Number	Coverage Type (medical or prescription)	Covered Person(s)	Monthly / Quarterly Premium Paid
Example: Elixir	*1234567890*	*Prescription*	Jane	*$19.80*
Elixir	*1234567890*	*Prescription*	Joe	*$19.80*
United Healthcare	*0987654321*	*Medical*	Jane	*$219.00*
United Healthcare	*0987654321*	*Medical*	Joe	$160.00

I certify that I/We have been enrolled in the above insurance plans which provide basic hospitalization, medical/surgical, and/or prescription coverage for the period indicated, and that I have paid the premiums as stated above. The amounts submitted do not include payments for coverage of Medicare Part B, Dental, Vision or other ineligible coverages and are subject to annual auditing.

Print Name: ______________________________

***Signature:** ______________________________ **Date:** __________________________

Forms may be submitted to Human Resources, along with supporting documentation, in any of the following ways (electronic submission recommended): 1) via email, as a pdf or legible photo attachment, to hroffice@lafayette.edu; 2) via fax to 610-330-5720; 3) via USPS to Human Resources,12 Markle Hall, Easton, PA 18042

Updated 1/1/2022