REQUEST FOR REIMBURSEMENT

RETIREE HEALTH INSURANCE FUNDING ASSISTANCE PROGRAM

Please reimburse me for my health insurance premium payments to:

____

For these three months:

____________/___________/___________

My monthly retiree health insurance premium assistance amount is:

$_______________________

I have enclosed proof of payment in the form of:

_____A copy of the bills from the insurance carrier and a copy of the checks or the credit card statements with charges highlighted

OR

_____A copy of my spouse's pay stubs showing deductions for health insurance

OR

_____Other (Explain)

I understand that if I pay my health insurance premiums yearly, I need to submit this form each quarter for reimbursement. If I cancel or change my health insurance at any time, I must notify Metro Wastewater Reclamation District Payroll in writing immediately. Failure to abide by the above provisions when requesting reimbursement for health insurance premiums coverage outside of the District's plan may result in penalties up to and including disqualification for plan benefits.

Retiree Name: (Please Print)____________________________________

Retiree Address: ____________________________________

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Retiree Signature: ____________________________________ Date:__________

Please return this form with proof of payment to Payroll.