Medical Premium Reimbursement Claim Form

HealthNow Administrative Services

Mail Form To:
P.O. Box 211034
Eagan, MN 55121

Group Name:
Community College of Philadelphia

Group Number
80010P

Section A: To be completed by Employee

Employee's Full Name	Date of Birth Mo.	Day	Year	Social Security Number

Street Address ☐ Check if new address City State ZIP Code

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married Ph.# : - -

Last Semester Worked: / / ☐Pool I – II (less than 8 Seniority Units) ☐Pool III (8 or more Seniority Units)

Section B: List of Reimbursable Expenses

In order to be eligible for Medical Premium Reimbursement, proof of payment is required. You are required to attach a copy of pay stubs for each month for which you request coverage, or a letter from the health insurance plan stipulating coverage and the amount of your contribution. Remember that you are entitled to reimbursement only for months during which you were eligible for benefits according to the PT/VL contract.

Month	Premium	Amount Due

Please indicate the name of the Plan in which you are covered. If you are a dependent, indicate the name of the member under whom you are enrolled as a dependent.

Name of Plan _____ Member's Name _____

Group # _____ Primary Insured ☐ Self ☐ Spouse Payroll Deductions (if applicable) ☐ Self ☐ Spouse

Type of Coverage ☐ Individual ☐ Emp. + Spouse ☐ Emp. + One ☐ Family

Premium Rate Structure for this coverage: $_____ Individual $_____ Emp. + Spouse

$_____ Emp. + One $_____ Family

Section C: Authorization

I certify that I have incurred the expenses for which reimbursement is claimed from the Medical Premium Account. I further certify that I am eligible to receive benefits under this program.

Employee Signature _____ Date _____