DEPARTMENT OF HUMAN RESOURCES

2331 Mill Road, Room 301
Alexandria, Virginia 22314
Phone: 703.746.3777

RETIREE MEDICAL INSURANCE REIMBURSEMENT PLAN

NAME OF RETIREE _____
(PLEASE PRINT)

DATE OF BIRTH _____

ADDRESS _____

TELEPHONE Home: _____ **Cell:** _____

EMAIL ADDRESS _____

Insurance Plan Name: _____ **Spouse Plan? Yes** ___ **No** ___

Plan Year (Month/Year): _____

If the coverage is in your spouse's name, please be sure to provide the rate for both individual and family premiums. This information is required to determine the cost of adding you to your spouse's plan only.

Monthly premiums: Individual $_____ **Family: $**_____ **Other:** _____

Proof of coverage attached (please check all that apply):

_____**Statement of monthly premiums from plan carrier or employer.**

_____**Copies of payment coupons and cancelled checks.**

_____**Copies of payroll check stubs reflecting payroll deductions for health insurance coverage.**

I request to be reimbursed for the cost of healthcare premiums I have paid as shown above. I understand that I must notify the Department of Human Resources immediately if my premiums change or if I am no longer qualified for this program.

Date _____ **Signature** _____