609 South Gold Street **Siskiyou County Office of Education** Yreka, CA 96097
Providing Educational Leadership, Resources And Services To Districts And Schools
To Ensure Learning For All Students

INSURANCE PREMIUM REIMBURSEMENT CLAIM FORM

To: Siskiyou County Office of Education

Note: *Federal law requires that you submit a written statement such as an itemized bill from the benefit provider. You will not be entitled to claim this expense as a tax deduction. Please allow a minimum of 10 business days for a reimbursement check to be issued.*

Name: _____
Last ***First*** ***Middle Initial***

Address:_____
City ***State*** ***Zip Code***

Telephone Number: _____

MEDICAL CARE EXPENSE(S)				
Date Paid	**Paid To**	**Coverage Period**	**Description of Expense**	**Net Amount**
			Subtotal	
			Total Medical Expense(s)	

PLEASE ATTACH*:*
Evidence of Payment: Canceled check, bank statement copy, credit card statement, or retirement check.
Billing: Invoice, coupon, or statement. (Must show name of insured, time period and amount due.)
Reimbursable Costs: Health Insurance, RX Plan, Medicare Part D, Medicare Supplement Health Insurance, and/or Dental Insurance.

READ CAREFULLY:
The undersigned participant in Retiree Benefits with the Siskiyou County Office of Education certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred as stated. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned.

_____ _____
Employee Signature Date

For year-end closing purposes, please submit final fiscal year claim by July 15th.

For Plan Administrator Use Only	Summary	For Employer Use Only
Payment Authorized By:	Monthly Medical Cap:	Check No. and Amount:
Amount Authorized:	Monthly Dental Cap:	Date:
Date Authorized:	Account String: 01-0000-0-3701/3702-0000-7600	