



City of Alexandria, Virginia  
 Human Resources Department  
 City Hall P.O. Box 178  
 Alexandria, VA 22314

**RETIREE MEDICAL INSURANCE REIMBURSEMENT STATEMENT**

NAME OF RETIREE \_\_\_\_\_  
 (PLEASE PRINT)

DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

I request reimbursement for my cost of health insurance for the quarter checked below.

___ *January, February & March	Monthly \$ _____	X _____	Premiums pd:
___ April, May & June	Monthly \$ _____	X _____	Premiums pd:
___ *July, August & September	Monthly \$ _____	X _____	Premiums pd:
___ October, November & December	Monthly \$ _____	X _____	Premiums pd:

**\* Proof of Health Insurance must be provided during these months.**

Insurance Plan Name: \_\_\_\_\_ Spouse plan? Yes \_\_\_\_\_ No \_\_\_\_\_

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: \_\_\_\_\_

**Please note: Reimbursement forms must be received by the 15<sup>th</sup> of the 3<sup>rd</sup> month of each quarter. We are unable to make retroactive payments. Any adjustments will be made in your next reimbursement check.**

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

- \_\_\_ Statement from plan carrier or employer.
- \_\_\_ Copies of payment coupons **and** canceled checks.
- \_\_\_ Copies of payroll check stubs.

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

Date \_\_\_\_\_ Signature \_\_\_\_\_