WATERVLIET CITY SCHOOL DISTRICT

Health Insurance Co-Pay Reimbursement Form

NAME OF EMPLOYEE: _____

ADDRESS: _____

PHONE NUMBER: _____

***IMPORTANT*: Signature required below**

I certify the information here is true and correct, that the expenses incurred were for myself, spouse, or qualified dependents, and that these expenses are not reimbursable under any other health plan coverage. **RECEIPTS MUST BE ATTACHED**.

Date: Employee Signature:

Name	Relationship to Employee	Amount	Date(s) of service	Provider