Roofers Local No. 20 Health and Welfare Fund

6321 Blue Ridge Blvd., Suite 101, Raytown, MO 64133 ♦ (816) 313-9427

Spousal Employment Insurance Premium Reimbursement Form

Note: This form must be attached to your proof of payment of premiums for insurance through your spouse's employer. This form is due by the 15th of the month following the end of the quarter. Eligible reimbursement requests received late will be made the next quarter.

Participant Name: ______________________________

Participant SS#: ______________________________

Spouse Name: ______________________________

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2024 Reimbursement Policy—the Fund will reimburse (on a quarterly basis) 100% of contributions paid by the spouse for the employee only portion of the cost of coverage, up to a monthly maximum of $200.00.

This proof of Payment Form is for the eligibility quarter of: (Please check the appropriate box.)

- ☐ 1st Quarter—January, February, and March
- ☐ 2nd Quarter—April, May, and June
- ☐ 3rd Quarter—July, August, and September
- ☐ 4th Quarter—October, November, and December

I have attached the necessary proof of payment in the form of:

☐ Copies of my paycheck stubs showing a payroll deduction in the amount of $________ for ***employee-only coverage*** for the eligibility quarter indicated above.

Or

☐ Verification from my employer on their letterhead verifying that I paid $________ for ***employee-only coverage*** for the eligibility quarter indicated above.

Note: Written verification that the above amount is for employee-only single coverage must accompany this form with each submission.

I hereby certify that the information given in this form is true, correct, and complete to the best of my knowledge.

Participant's Signature: ______________________________ **Date:** ______________

Spouse's Signature: ______________________________ **Date:** ______________