Please return form to the Benefits Department by emailing Benefits@ccp.edu

COMMUNITY COLLEGE OF PHILADELPHIA

Medical Premium Reimbursement Claim Form

Name:

J Number:

Pool Level:

Because the medical premium reimbursement described below is considered "integrated" minimum essential medical coverage that could affect your ability to enroll in Health Insurance Marketplace coverage and/or qualify for a premium tax credit, you have the choice to opt out of participating in the medical premium reimbursement for the period in which you are eligible. If you do not wish to participate in the medical premium reimbursement, please check the box below and sign and return this form to **Benefits@ccp.edu** within a month of your eligibility for the medical premium reimbursement benefit based on the semester/term you are working.

To opt out of this benefit, please sign below. By signing below, I am choosing not to receive the medical premium reimbursement benefit for the following semester/term: _____.

Employee Signature: _____ Date: _____

In order to be eligible for medical premium reimbursement, proof of payment is required. You are required to attach a copy of pay stubs for each month for which you request reimbursement, or a letter from the health insurance plan stipulating coverage and the amount of your contribution. You are entitled to reimbursement for only months during which you were eligible for benefits according to the PT/VL contract. Please submit all documentation as a single PDF. You can request reimbursement 6-months back from the processing date. For example:

- February 15th 6 – month back count would include August thru January
- May 15th 6 – month back count would include November thru April
- August 15th 6 – month back count would include February thru July
- November 15th 6 – month back count would include May thru October

The maximum amount of reimbursement in any month for Pools 1 & 2 is $399.76. The maximum reimbursement in any month for Pools 3+ is $599.64.

Months Requested for Reimbursement

Please complete all of the information on this form to submit a request for reimbursement for medical premiums paid through another employee or through your spouse's employer.

	Month	Amount Requested	Source (i.e.) Other Employment, Spouse
1			
2			
3			
4			
5			
6			

Please indicate the name of the Plan in which you are covered. If you are a dependent, indicate the name of the member under whom you are enrolled as a dependent.

Name of Plan: _____

Subscriber's Name: _____

Relationship: ☐ Self ☐ Spouse

Type of Coverage

☐ Individual ☐ Employee + Spouse ☐ Employee +1 ☐ Family

Premium Rate Structure for this coverage:

Individual $ _____ Employee + Spouse $ _____ Employee + 1 $_____ Family $ _____

I certify that I have incurred the expenses for which reimbursement is claimed from the medical Premium Account. I further certify that I am eligible for benefits under this program and that I have actively worked for the months in which I am requesting reimbursement.

Employee Signature: _____ Date: _____