# Mo-Kan Sheet Metal Workers Welfare Fund

**P.O. Box 300019**
**Kansas City, MO 64130-0019**
**(816) 531-0334 or Toll Free at (866) 531-5488**
**(816) 836-6553 FAX**

## 2020 Spouse 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 reimbursement can be submitted monthly.

Member Name: _____

Member SS#: _____

Spouse Name: _____

*Reimbursement Policy* – The Fund will reimburse 100% of your contribution up to a monthly maximum of $200.00 for medical and prescription **employee only** coverage.* Dental and vision coverage is not reimbursable. To participate in the program for the first time, please complete and return the spousal verification form which can be found on our website. Certain medical plans are not eligible for the benefit (see below on HDHP plans) so this form will help us determine if a members plan qualifies. Mokan will also require a new spousal verification form if you change employers (which changes your medical plan) or if you change medical plans from year to year even though you are with the same employer.

This proof of Payment Form is for the month of: (Please check the appropriate box)

| | | |
|---|---|---|
| ☐ January 2020 | ☐ May 2020 | ☐ September 2020 |
| ☐ February 2020 | ☐ June 2020 | ☐ October 2020 |
| ☐ March 2020 | ☐ July 2020 | ☐ November 2020 |
| ☐ April 2020 | ☐ August 2020 | ☐ December 2020 |

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

☐ Copies of my paycheck stubs for each month being requested, showing a payroll deduction in the amount of $_____ for ***employee only coverage*** for the eligibility month indicated above.

Or

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

**Note: Written Verification that the above amount is for employee only single coverage must accompany this form with each submission either by submitting a benefit rate summary or the employer letter stating type of coverage the spouse is enrolled in.**

***Mokan does not reimburse for high deductible health plans (HDHP) unless it is the only medical plan offered by your employer or if all medical plans offered by your employer are HDHP. If you have enrolled in a high deductible health plan, Mokan may request documentation from your employer showing all medical plans offered to make determination if the plan is reimbursable under the working spouse program.***

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

**Member's Signature: _____ Date: _____**

**Spouse's Signature: _____ Date: _____**