2025 Spousal Reimbursement Form

P.O. Box 300019 Kansas City, MO 64130
P#: (816) 531 0334 F#: (816) 753 7252

Note: This form must be attached to proof of payment for medical insurance premiums through your spouse's employer.

Subscriber Name | Please Print:_____

Mo-Kan ID Number: KDLMOKA

Spouse Name | Please Print:_____

Reimbursement Policy

- The Fund will reimburse 100% of your contribution up to a monthly maximum of $200 for **medical and prescription employee only coverage.** Dental and vision coverage are not reimbursable. Certain medical plans are not eligible for the benefit
- To participate in the program for the first time, please complete and return the Spousal Verification Form which can be found on our website at www.MoKanSheetMetal.org. Mo-Kan will also require a new Spousal Verification Form if there is a change in employer, or if the medical plan changes from year to.
- This form helps to determine if an enrolled spouse's plan qualifies for reimbursement.

This reimbursement form is for the month of:

☐ January 2025	☐ May 2025	☐ September 2025
☐ February 2025	☐ June 2025	☐ October 2025
☐ March 2025	☐ July 2025	☐ November 2025
☐ April 2025	☐ August 2025	☐ December 2025

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

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

☐ Verification from employer on their letterhead to verify that I paid $_____ for employee only coverage for the eligibility month(s) 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 an employer letter stating the type of coverage the spouse is enrolled in. **Mo-Kan does not reimburse for high deductible health plans** unless it is the only medical plan offered by your employer or if all medical plans offered by your employer are high deductible health plans. If you have enrolled in a high deductible health plan, Mo-Kan may request documentation from your employer showing all medical plans offered to determine 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.

Subscriber Signature:_____ **Date:**_____

Spouse Signature:_____ **Date:**_____