

# 2026 SPOUSAL REIMBURSEMENT CLAIM FORM



P.O. Box 300019 Kansas City, MO 64130

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

Subscriber Name | \_\_\_\_\_

Spouse Name | \_\_\_\_\_

MOKAN ID# | \_\_\_\_\_

### 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](http://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 year.
- This form helps to determine if an enrolled spouse's plan qualifies for reimbursement.

### THIS REIMBURSEMENT FORM IS FOR THE MONTH OF

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> January 2026  | <input type="checkbox"/> May 2026    | <input type="checkbox"/> September 2026 |
| <input type="checkbox"/> February 2026 | <input type="checkbox"/> June 2026   | <input type="checkbox"/> October 2026   |
| <input type="checkbox"/> March 2026    | <input type="checkbox"/> July 2026   | <input type="checkbox"/> November 2026  |
| <input type="checkbox"/> April 2026    | <input type="checkbox"/> August 2026 | <input type="checkbox"/> December 2026  |

### 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 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 \_\_\_\_\_