REQUEST FOR REIMBURSEMENT

Date of request: ______________________________ Check payable to (full name): ______________________________

Name: ______________________________ Mailing address: ______________________________

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Email: ______________________________ Cell phone: ______________________________

1. Reimbursements will be processed in March, June, September, and December. Please submit the completed reimbursement form with required attachments by the 15th of each said month. Reimbursements will be processed once the completed request for reimbursement form and required proof of premium payment is received."
2. Attach proof of medical and/or dental insurance coverage and proof of premium payments.
3. Return to the City of Vernon's Human Resources Department.
4. Reimbursement form and attachments will be reviewed, approved, and forwarded to the Finance Department for processing of payment.
5. Receipts submitted more than 120 days from the date of the expense may be declined.

Line	Month/Year of Coverage Expense	Amount	Expense Description
1			
2			
3			
4			
	Total:		

I certify the following:

☐ I received a retiree medical contribution towards health/medical insurance premiums through my employment with and/or retirement from the Fire Protection District of Los Angeles County in the amount of $_________/month during the reimbursement period of ______________________ through ______________________.

☐ I did not receive any retiree medical contributions for health/medical premiums.

Print Name: ______________________________ **Signature:** ______________________________

Human Resource's Use Only:

Approved by: ____________________ **Date:** __________ **Account #:** ________________ **Total amount approved:** ______________