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

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 form is due by the 15th of the month following the end of the quarter.

Member Name: _____

Member SS#: _____

Spouse Name: _____

Reimbursement Policy – the Fund will reimburse 100% of your contribution up to a monthly maximum of $200.00.

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

- ☐ 1st Quarter – January, February, and March **(Reimbursement Dates: 04/01/12-04/15/12)**
- ☐ 2nd Quarter – April, May and June **(Reimbursement Dates: 07/01/12-07/15/12)**
- ☐ 3rd Quarter – July, August, and September **(Reimbursement Dates: 10/01/12-10/15/12)**
- ☐ 4th Quarter – October, November, and December **(Reimbursement Dates: 01/01/13-01/15/13)**

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 quarter indicated above.

  Or

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

Note: Written Verification that the above amount is for employee only single coverage must accompany this form with each submission.

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:**_____