PRINCETON CITY SCHOOL DISTRICT
DRUG REIMBURSEMENT PLAN
REIMBURSEMENT REQUEST FORM

1. EMPLOYEE INFORMATION

Employee Name: _____

Home Address: _____

_____

Social Security Number: _____ **Phone #:** _____

Insurance Coverage in Force:	**[ ] Employee**	**[ ] Employee + 1**	**[ ] Family**
Plan Year Out of Pocket Maximum:	**$ 600.00**	**$ 1,200.00**	**$ 1,800.00**

2. REIMBURSEMENT REQUEST

Please include proofs of drug purchases with your claim request. A copayment receipt from your pharmacy or a mail order receipt may be used with your claim. Claims must be submitted no later than 90 days following the end of a plan year to be eligible for reimbursement.

[ ] I qualify for Princeton City School District's drug reimbursement program. Attached are my drug copayment receipts meeting and exceeding my medical insurance plan "out of pocket" maximum.

[ ] I have qualified for Princeton City School District's drug reimbursement program and have already submitted receipts exceeding my "out of pocket" maximum. Attached are new receipts for additional reimbursement.

Reimbursement Amount Requested: _____

3. EMPLOYEE CERTIFICATION

I hereby certify that the attached expenses for which reimbursement is claimed from the Drug Reimbursement Plan have been incurred by me and/or my eligible dependents and have not or will not be reimbursed by any other source. The receipts I am submitting apply to and exceed the out of pocket maximum designated by my group medical insurance plan through Princeton City School District..

Employee's Signature: _____ Date: _____

CHARD, SNYDER & ASSOCIATES, INC.

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