AFSCME and State of Michigan
Health Insurance Assistance Application

Please send a copy of your insurance payment coupon and the check you are sending to pay the bill along with this completed application form.

Your ***AFSCME*** Union has negotiated the right to reimburse a portion of your health insurance premiums from the Employee Education and Resource Fund. *One (1) month of your health insurance will be reimbursed from this Fund **(if you are not covered by <u>any</u> other health insurance)**. This includes insurance coverage from your spouse, insurance from other employment, medicare, Medicaid, SSI, or other types of insurance.

You must complete the lower portion of this form and attach both a copy of the health insurance billing showing the time period billed, as well as a copy of your proof of payment. Payment from the Fund will be for <u>health insurance only</u>, and will not include vision, dental, life or long term disability.

REQUEST FOR HEALTH INSURANCE REIMBURSEMENT

EMPLOYEE NAME_____ AGENCY_____

EMPLOYEE ADDRESS_____

EMPLOYEE ID#_____ LAST 4 DIGITS OF SS#_____

CLASSIFICATION_____ LOCAL UNION NO_____

PHONE_____ ***IF RECALLED, GIVE DATE***_____

<u>CURRENT COVERAGE</u>: (Check One)

_____ EMPLOYEE ONLY _____ EMPLOYEE & SPOUSE

_____ EMPLOYEE & CHILD(REN) _____ EMPLOYEE, SPOUSE & CHILD(REN)

By my signature, I affirm that ***<u>NO</u>*** other health insurance coverage is provided for myself, or those indicated above.

EMPLOYEE
SIGNATURE_____ DATE_____

MAIL TO:

MICHIGAN _AFSCME_ COUNCIL 25
ATTN: Stacie Dineen
INSTITUTIONAL UNIT HEALTH INSURANCE REIMBURSEMENT
1034 N. Washington Ave.
Lansing, MI 48906

SD/rwl:iuoe324aflcio

*A maximum of three (3) months reimbursement may be approved during the period of layoff.