

**NEW HAVEN RETIRED EMPLOYEES  
HEALTH BENEFIT PLAN AND TRUST  
REIMBURSEMENT CLAIM FORM**  
For Fiscal Year July 1, 20\_\_\_\_ to June 30, 20\_\_\_\_  
(complete a separate claim for each health plan)

Certificated     Classified     Management

Retired Employee \_\_\_\_\_  
Spouse/Domestic Partner Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Health Plan Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Requesting reimbursement for the following dates of coverage and **accompanying proof of payment is attached for the current calendar year:**

COVERAGE DATES	AMOUNT CLAIMED			ELIGIBLE AMOUNT (District Use Only)
	Self	Spouse <i>(if applicable)</i>	Total	
<b>TOTAL:</b>			\$	\$

I certify that the above accurately states the premium amounts I have paid for benefits that qualify for reimbursement by the Retired Employees Health Benefit Plan and Trust.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail to:**            New Haven Unified School District  
Retired Employees Health Benefit Plan and Trust  
34200 Alvarado Niles Road, Union City, CA 94587

For District Use Only	
<b>District Approval:</b>	<b>Reimbursable Amount :</b>
<b>Date:</b>	Budget Code:
	<input type="checkbox"/> Cert/Mgt:    710.1180.0.0000.6000.5890.510.2000
	<input type="checkbox"/> Classified:    710.1181.0.0000.6000.5890.510.2000
	<input type="checkbox"/> Board/Supt:    710.1182.0.0000.6000.5890.510.2000