

**NEW HAVEN CSEA EMPLOYEES
HEALTH BENEFIT PLAN
REIMBURSEMENT CLAIM FORM FOR OFFICE VISITS
Oct 1, 2009 to June 30, 2011**

Employee _____ SSN: _____ Emp ID: _____
 Spouse/Domestic Partner/Dependents Names _____
 Mailing Address _____
 Phone _____ E-mail _____
 Health Plan Name _____

Per the CSEA Memorandum of Understanding regarding the CalPers Medical Plan, I am requesting a \$5.00 reimbursement for Office Visit(s) for the following date(s).

I have attached the proof of payment for each Office Visit.

Date of Visit	Full Name of Claimant	Amount Paid	ELIGIBLE AMOUNT (District Use Only)
TOTAL:		\$	\$

I certify that the above accurately states the premium amounts I have paid for benefits that qualify for reimbursement.

Signature _____ Date _____

**Mail to: New Haven Unified School District
34200 Alvarado Niles Road, Union City, CA 94587**

For District Use Only

District Approval:	Reimbursable Amount :
Date:	Budget Code:
	<input type="checkbox"/> Classified: 010-0000-0-0000-7490-5810-510-4000 (062449)

All claims must be for you or dependents on your Medical Plan. Proof of payment is required and may consist of receipt given at time of service. Return form to Personnel Office, ESC.