Wilkin County Family Service Agency
PO Box 369 * 227 6th Street N
Breckenridge, MN 56520
Phone: 218-643-7161
Fax: 218-643-7175

COST EFFECTIVE VOUCHER
REQUEST FOR HEALTH INSURANCE PREMIUM REIMBURSEMENT

_____ _____
Name Phone Number

_____ _____
Mailing Address Reimbursement Month

_____ $_____
City, State, Zip Code Total Monthly Insurance Deduction

I certify that this statement, the amounts claimed and attachments are true, correct and complete to the best of my knowledge and believe the payment for the amount claimed has not been received.

_____ _____
Signature Date

You must attach proof of premium payment such as:
A statement from the insurance company, paystub(s) with health insurance deductions, etc.
This form needs to be returned to our Agency by the 5th of each month in order for you to receive reimbursement timely and is to CONTAIN ONLY THE CLAIM FOR THE PRIOR MONTH.

(For example – Jan claims need to be submitted by Feb 5th, to ensure reimbursement in the month of Feb)

***************************************For Office Use Only***********************************

Case # _____ PMI # _____ Reimbursement Amount $_____

Obligation ID _____ Worker 's Initials_____ Date_____

Additional comments _____

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