Mississippi Library Commission

HEALTH AND LIFE REIMBURSEMENT REQUEST FORM

Submit a separate form for each coverage month / Submit a request each month by the 10th

Library/Library System:

Coverage Month:

Health Insurance Subgrant Number:

Total Participant Count	Monthly Premium	Total Premium
	$ 437.00	$ 0.00
ADD Previous Month Adjustment	**DEDUCT Previous Month Adjustment**	**Total Adjustment**
$ 0.00	$ 0.00	$ 0.00
Reason for Adjustment		
Total Health Insurance Amount		$ 0.00

Life Insurance Subgrant Number:

Total Life Face Value	Divided by 1,000	Per Unit Cost	Total Premium
	0	$ 0.10	$ 0.00
ADD Previous Month Adjustment	**DEDUCT Previous Month Adjustment**		**Total Adjustment**
$ 0.00	$ 0.00		$ 0.00
Reason for Adjustment			
Total Life Insurance Amount			$ 0.00

Total Health and Life Reimbursement Requested Amount $ 0.00

By signing below, I certify the information above is true, correct and in accordance with the Terms and Conditions of this subgrant and payment is due and has not previously been paid by MLC.

Library/Library System Director's Signature _____ Date _____

MLC USE ONLY

I hereby certify that the above payment has been verified and is due, correct, and has not been paid previously. This payment is being made in accordance with the provisions of the grant and satisfies all statutory requirements governing this payment. All supporting documentation associated with this request is maintained at the agency.

Authorized MLC Staff _____ Date _____