

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 Pre	mium	Total Premium
ADD Previous Month Adjustmen	DEDUCT nt Previous Month A		Total Adjustment
Reason for Adjustment			
Total Health Insurance Amount			
Life Insurance Subgrant Number:			
Total Life Face Value	Divided by 1,000	Per Unit C	ost Total Premium
ADD Previous Month Adjustmen	DEDUCT nt Previous Month A		Total Adjustment
Reason for Adjustment			
Total Life Insurance Amount			
Total Health and Life Reimbursement Requested Amount			
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			
hereby certify that the above payment has been verified and is due, correct, and has not been paid previously. This payment is being made accordance with the provisions of the grant and satisfies all statutory requirements governing this payment. All supporting documentation associate in this request is maintained at the agency.			