



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           |
|-----------------------------------------|--------------------------------------------|-------------------------|
| <input type="text"/>                    | <input type="text"/>                       | <input type="text"/>    |
| <b>ADD</b><br>Previous Month Adjustment | <b>DEDUCT</b><br>Previous Month Adjustment | <b>Total Adjustment</b> |
| <input type="text"/>                    | <input type="text"/>                       | <input type="text"/>    |
| Reason for Adjustment                   | <input type="text"/>                       |                         |
| <b>Total Health Insurance Amount</b>    |                                            | <input type="text"/>    |

Life Insurance Subgrant Number:

| Total Life Face Value                   | Divided by 1,000                           | Per Unit Cost           | Total Premium        |
|-----------------------------------------|--------------------------------------------|-------------------------|----------------------|
| <input type="text"/>                    | <input type="text"/>                       | <input type="text"/>    | <input type="text"/> |
| <b>ADD</b><br>Previous Month Adjustment | <b>DEDUCT</b><br>Previous Month Adjustment | <b>Total Adjustment</b> |                      |
| <input type="text"/>                    | <input type="text"/>                       | <input type="text"/>    |                      |
| Reason for Adjustment                   | <input type="text"/>                       |                         |                      |
| <b>Total Life Insurance Amount</b>      |                                            |                         | <input type="text"/> |

**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

**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