

**GLOVERSVILLE ENLARGED SCHOOL DISTRICT  
234 LINCOLN STREET  
GLOVERSVILLE, NY 12078**

**HEALTH INSURANCE REIMBURSEMENT REQUEST**

Please list all out-of-pocket health care expenses submitted to but not covered by your health insurance. All approved expenses incurred beyond \$100 per person, per year, will be reimbursed to you by the Gloversville Enlarged School District. Only retirees and/or spouses that pay no premium are entitled to claim reimbursement.

Your Name: \_\_\_\_\_

Blue Shield ID # \_\_\_\_\_

Mailing Address: \_\_\_\_\_

I am (check one) :

retiree

spouse of retiree

Phone number: \_\_\_\_\_

| Date of Service         | Provider Name (Physician, pharmacy, hospital, etc) | Amount * |
|-------------------------|--|----------|
|                         |  |          |
|                         |  |          |
|                         |  |          |
|                         |  |          |
|                         |  |          |
|                         |  |          |
|                         |  |          |
|                         |  |          |
|                         |  |          |
| <b>Total Expenses →</b> |  |          |

\* Attach original receipts or statements along with this form. Do not include amounts paid or eligible for payment under any other health care plan. Neglecting to submit required records may delay reimbursement. Additional forms may be used if necessary. Signature is required for reimbursement.

\_\_\_\_\_  
Signature of person requesting reimbursement (retiree/spouse or agent)

\_\_\_\_\_  
Date

|                                       |                                  |
|---------------------------------------|----------------------------------|
| <b>GESD Business Office Use Only:</b> |                                  |
| Approved for payment by: _____        |                                  |
| Approval Date: _____                  | Date Reimbursement Issued: _____ |