



Health Insurance Reimbursement Form

To qualify for this benefit, you must have been paid for working an average of at least 25 hours per week for the two consecutive calendar months immediately preceding the first month for which you submit a reimbursement request. Once you qualify, and starting in the first month after the two qualification months, Cambridge will reimburse up to \$100 per month toward health insurance premiums you have paid (out of pocket) to insure yourself, spouse and/or dependents **as long as you continue to receive pay for working a weekly average of 25 hours per month**. Should you fail to work the requisite number of hours for two successive months, after having met the initial qualification criteria, you will need to requalify (as above).

At the end of each month for which you qualify (**by no later than the 15th of the next succeeding month**), you will need to provide us with a request for reimbursement on this form as well as evidence of your payment for coverage for that month (in the form of an insurance company invoice and cancelled check copy, credit card entry, etc). We will include your reimbursement up to \$100 in your regular weekly paycheck on or before the 30th of the month.

FOR EXAMPLE: If you meet the 25 hour per week criteria for the months of January, February and March, please submit your request for reimbursement and evidence of payment for March coverage no later than April 15th. You should receive your reimbursement of up to \$100 no later than April 30th.

Please note: The insurance coverage must be in your name and we reserve the right to deny reimbursement should we deem at our sole discretion that the evidence of coverage and payment you have provided is insufficient. Your request for reimbursement for a given month and accompanying documentation must be received in our offices no later than the 15th of the month immediately following and we reserve the right to deny reimbursement against requests received later than this date.

Please understand that these benefits are offered at the sole discretion of Cambridge and may be amended or discontinued at any time without advance notice. All reimbursements will be paid net of applicable withholding taxes.

Employee: _____ **File:** _____

Date: _____

Reimbursement Requested for the month of: _____

Insurance Company: _____

Monthly Payment Amount: _____ (please attach evidence of coverage and payment, such as insurance company invoice and cancelled check/credit card entry etc.)

Hours Worked (per Cambridge timesheet as approved by client) for the month for which reimbursement is requested:

Week Ended _____ **Total Hours** _____

Week Ended _____ **Total Hours** _____

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Week Ended _____ **Total Hours** _____

For Cambridge use only:

Date Rec'd: _____ **Approved By:** _____ **Date Paid:** _____