City of Henderson Kentucky
Police & Fire Pension Fund
Hospital/Medical Insurance Reimbursement

Name: _____

Address _____

City, State & Zip Code _____

Phone number _____

Please check the box below that applies to your request:

☐ Request for retiree or spouse that has not reached the age to qualify for Federal Medicare insurance

or

☐ Request for supplemental health insurance benefit to retirees and their spouses of Medicare age.

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Month: _____ Year: _____ Amount: $_____

Grand total of request: $ _____

I hereby certify that the information on this claim form is correct. I understand any person, with intent to defraud or knowing that he or she is facilitating a fraud submits a claiming containing a false or deceptive statement is guilty of insurance fraud.

_____ _____

Signature Date