HUMAN RESOURCES
Illinois State University

INSTRUCTIONS
Domestic Partner Health Insurance Premium Reimbursement

1. If you have not already done so, complete the Statement of Domestic Partnership.

2. Compile three forms of documentation (as listed under #5 on the *Statement of Domestic Partnership*) and mail copies of those and an original *Statement of Domestic Partnership (if not already on file)* by the reimbursement deadline date to Human Resources, Benefit Services , Campus Box 1300, Normal, Il 61790-1300.

3. Complete the *Medical Premium Reimbursement Form (*provided below*).*

4. If reimbursement is requested for health insurance for children of your domestic partner, attach a photocopy of the child's birth certificate in order to show the relationship to your domestic partner.

5. Attach written documentation of medical insurance payment and coverage, showing dates of coverage and the names of all individuals covered. Refer to the *Medical Premium Reimbursement Form* for acceptable documentation.

6. Mail the completed *Medical Premium Reimbursement Form* and required documentation to Human Resources, Benefit Services as listed in #2 above.

7. *Medical Premium Reimbursement Forms* must be received by the first day of February, May, August and November to be eligible for reimbursement for the applicable period and for inclusion in paychecks at the end of those months.

8. Because this is a taxable benefit, the reimbursement will be processed as additional pay through the payroll system. Taxes and other payroll withholdings will apply to this additional income.

Illinois State University – Medical Premium Reimbursement Claim Form

Employee *Please Print* **Domestic Partner or Child(ren) of Domestic Partner**

Name: _____
Last First Middle Initial

Home Address:

_____
Street Apartment

_____
City State Zip Code

Home Phone: (___) _____

University I.D.: _____

Domestic Partner (Name): _____
Last First Middle Initial

Home Phone: (___) _____

Child of Domestic Partner: _____
Last First Middle Initial

Social Security Number: _____ Date of Birth: _____

Child of Domestic Partner: _____
Last First Middle Initial

Social Security Number: _____ Date of Birth: _____

Initial Filing Only: Attach photocopy of child's birth certificate in order to show relationship to employee's domestic partner.

Domestic Partner Health Insurance Information

_____

Employer Name and Mailing Address (only applicable if partner is participating in a group medical plan)

_____

Name and Address of Insurance Company or HMO Plan in which partner is covered

Does your partner receive insurance benefits as an employee of the State of Illinois, Illinois State University, or another organization which participates in the Illinois State Employee Group Insurance Program? ☐YES ☐NO

Note: A domestic partner who is eligible to participate in the State of Illinois Group Insurance program is not eligible for premium reimbursement.

Domestic Partner Health Insurance Premium Information

Monthly health and dental premium paid by you or your partner:

Month _____ Amount $_____

Month _____ Amount $_____

Month _____ Amount $_____

So that we may process your claim as quickly as possible, please provide complete documentation:

1. Proof of payment (canceled checks, bank statement, or payroll stubs) and monthly health and dental premium paid (invoice or employer rate sheet) for each month/pay period
2. Proof of the actual monthly cost for health and dental insurance (invoice or employer rate sheet showing employee contribution amount)

Please check proof of payment enclosed: ☐ canceled check ☐ payroll stub ☐ other

Employee Authorization

I understand that providing false information on this form or failure to notify the Office of Human Resources in a timely basis of loss of eligibility for any of my dependents (including my domestic partner and any of his/her dependents) may result in disciplinary action up to and including termination of employment. I agree that if either event occurs, Illinois State University may recover damages for all losses and reasonable attorney's fees incurred by Illinois State University to recover such damages.

_____ _____
Employee's Signature Date

Return form to: Human Resources, Benefit Services, Campus Box 1300, Normal, Il 61790-1300