CITY OF JACKSONVILLE

CITY HALL, ST. JAMES BUILDING
117 WEST DUVAL STREET
JACKSONVILLE, FLORIDA 32202

REIMBURSEMENT REQUEST FORM
FLORIDA STATUTE § 112.1816

Employee Name: _____ Date: _____

Pursuant to Florida Statute § 112.1816, I am seeking reimbursement from the City of Jacksonville for the following out-of-pocket deductible costs, copay costs, and/or co-insurance costs which I have incurred due to the treatment of cancer.

$ _____	_____	_____
Cost	Date Incurred	Type of cost (out-of-pocket; copay; or co-insurance)
$ _____	_____	_____
Cost	Date Incurred	Type of cost (out-of-pocket; copay; or co-insurance)
$ _____	_____	_____
Cost	Date Incurred	Type of cost (out-of-pocket; copay; or co-insurance)
$ _____	_____	_____
Cost	Date Incurred	Type of cost (out-of-pocket; copay; or co-insurance)
$ _____	_____	_____
Cost	Date Incurred	Type of cost (out-of-pocket; copay; or co-insurance)

**** Please attach a copy of your Explanation of Benefits AND proof of payment/receipt for each of the above charges. ****

I hereby certify that the costs and expenses listed above are true and accurate, as shown in the attached documentation, and that I have not received/will not receive payment or reimbursement towards any of those costs/expenses from any other source.

_____ _____

Employee Signature Date