2015
INVOICE
City and County of Broomfield Retiree Medical Insurance
Reimbursement Request
Please attach proof of payment

Date: _____

Retiree Name: _____

Dependent Spouse Name (if applicable): _____

Phone #: Email address: _____

Please circle Month(s) of coverage for this reimbursement request:

January February March April May June July

August September October November December

Type of Insurance coverage: _____

(Example: Medicare, PERA deduction, AARP, Kaiser, etc.)

Amount of premium paid: $ _____

Amount of reimbursement requested: $ _____

HR Approval: _____

Please send requests to:

- **City & County of Broomfield**
  Attn: Human Resources
  One DesCombes Dr.
  Broomfield, CO 80020

- **Fax Number: 303-438-6328**

- **Email: hrrecruit@broomfield.org**