

Self-Certification of Premiums Paid for Professional Liability Insurance

Instructions

Complete Parts A, B and C of this form if you have paid premiums for a professional liability insurance policy and you are eligible for reimbursement. Reimbursement will be paid to you after October 1. Mail completed forms to:

Philadelphia Payroll Center
P.O. Box 245, Drop Point B5721
Attn: Professional Liability Insurance
Bensalem, PA 19020

PART A – Employee Information		
Name	Position Title	Social Security Number
Business Unit/Office		Office Telephone Number
PART B – Insurance Information		
Name of Insurance Carrier		Policy Number
Indicate if this is a new or continuing policy:		
<input type="checkbox"/> This is a NEW policy. I was not previously covered under professional liability insurance. The effective date of my policy is _____ . My premium is \$ _____ and is paid as follows: <input type="checkbox"/> per pay period <input type="checkbox"/> per month <input type="checkbox"/> per quarter <input type="checkbox"/> per year <input type="checkbox"/> other _____		
<input type="checkbox"/> This is a RENEWED policy. I have been continuously covered under professional liability insurance since _____ (month) _____ (year). My premium is \$ _____ and is paid as follows: <input type="checkbox"/> per pay period <input type="checkbox"/> per month <input type="checkbox"/> per quarter <input type="checkbox"/> per year <input type="checkbox"/> other _____		
PART C – Employee Authorization		
By signing below, I certify that I have paid the total premium indicated above to the insurance carrier for the dates of coverage listed in PART B.		
Employee Signature		Date Signed
Remarks		

Privacy Act Notice

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of your Social Security Number is authorized by Executive Order 11222, Sections 602, 701 and 702. The primary purpose of requesting the social security number (SSN) is to properly identify the employee. Failure to provide the requested information will result in the delay or denial of your requested reimbursement.

PART D – Payroll Center Use		
Processed:		Reimbursement Amount
Date:	Pay Period:	\$
Authorizing Signature		Remarks