



Tobacco Cessation Prescription Co-pay Reimbursement Form

Employee Name: _____

Department: _____

Circle One – Reimbursement is requested for:

Self/Spouse/Dependent

Name: _____

Date of Birth: _____

Co-Pay Amount Paid: _____

Prescription Supply (days): _____

Grayson County will reimburse up to 90 days of tobacco cessation prescription drug co-pays to employees, covered spouses, and adult dependents (18 and over). At this time, reimbursement will be offered until 11/1/15. See wellness initiative policy for drugs covered.

Please attach co-pay receipt to this form and submit to the Human Resources department.

Reimbursement cannot be made without receipt.