



UFT WELFARE FUND
52 BROADWAY, 7TH FLOOR, NEW YORK, NY 10004

**RIDER CLAIM FORM – 2018 BENEFIT YEAR
FOR NON-NYC HEALTH INSURANCE PLANS**

This form should be completed if you are a UFT Welfare Fund Retiree and you or your spouse / domestic partner (DP) is paying premiums covering you for a Health Insurance Plan that covers prescriptions, *other than from a NYC Health Plan.*

Please sign and return this form with the appropriate documentation to the UFT Welfare Fund. If you carry the health plan, please complete Sections I and II, and attach documentation showing your health insurance / prescription premium payment or deduction for the entire period. If your spouse/DP covers you under his/her health /prescription plan, then complete Sections I and III and attach your spouse's/DP's health insurance premium payment / deduction for the entire period. The UFT Welfare Fund reserves the right to request additional information.

SECTION I

Member's Full Name: _____ Telephone #: _____

Social Security Number or UFT Welfare Fund ID number: _____

Current Address: _____

Retirement Date: _____

SECTION II

Name of NON-NYC health plan that you are requesting reimbursement for: _____

Benefit Provider / Sponsor: _____ Indicate Single or Family Plan: _____

Monthly Payment: \$ _____ # of months paid: _____ Total Payment for 2018: \$ _____

Are you also covered under a NYC health plan? (*circle one*) YES NO Plan Name: _____

SECTION III (To be completed only when you are covered under your spouse's / DP's health plan)

Spouse's / DP's Name: _____

Spouse's / DP's Social Security Number: _____

Name of spouse's / DP's NON-NYC health plan that you are requesting reimbursement for: _____

Benefit Provider / Sponsor: _____ Indicate Single or Family Plan: _____

Monthly Payment: \$ _____ # of months paid: _____ Total Payment for 2018: \$ _____

Member's Signature

Date