



52 Broadway  
New York, NY 10004

# 2011 Medicare Part D Reimbursement Claim Form

(For Retired Members and their Spouse/Domestic Partner Only)

**Instructions For Filing:**

*Note: This benefit is for Retired Members and their Spouse/Domestic Partner Only.*

Check here if you are submitting a claim for yourself.

Attach a copy of your Annual Prescription Statement (Explanation Of Benefits) that indicates the 2011 5% Catastrophic Copayments, in excess of \$4,550.00.

Check here if you are submitting a claim for your spouse/domestic partner.

Attach a copy of your spouse's/domestic partner's Annual Prescription Statement (Explanation Of Benefits) that indicates the 2011 5% Catastrophic Copayments, in excess of \$4,550.00.

1 - Member must complete Box A (below) with all required information if claim is being submitted for member, and/or if the claim is being submitted for a spouse/domestic partner.

2 - This Form, plus all attachments, must be submitted to the UFT Welfare Fund for reimbursement NO LATER than February 1, 2012.

**BOX A**

**Must Be Completed By Member For ALL Claims:**

Member's Name : _____	Welfare Fund Alt. ID # or Soc. Sec. # : _____
Address : _____	File # : _____
City, State, Zip : _____	Health Plan : _____
Telephone # : _____	

**Must Be Completed If Claim Is For Spouse/Domestic Partner:**

Spouse's/Domestic Partner's Name : _____	Spouse's/Domestic Partner's Date of Birth : _____
Relationship to Member : _____	Spouse's/Domestic Partner's Soc. Sec. # : _____

Is your spouse/domestic partner covered by another insurance policy:  Yes  
 No

If yes, name of other insurance company and policy # : \_\_\_\_\_  
\*(You must also attach a copy of the Explanation of Benefits from that insurance company).

Calendar Year Requested : 2011

Total Dollar Amount Of All Calendar Year 2011  
5% Catastrophic Copayments, In Excess of  
\$4,550.00, As Indicated On The Attached EOB(s) : \$ \_\_\_\_\_

DECLARATION: To the best of my knowledge, the above information is true and correct and I or my spouse/domestic partner have received the services attached. In the event I receive an overpayment of benefits, on my behalf, or on behalf of my spouse/domestic partner, I am obligated to refund said overpayment to the Fund immediately.

Signature of Member : \_\_\_\_\_ Date : \_\_\_\_\_