



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

**RIDER CLAIM FORM – 2007 BENEFIT YEAR
FOR NON-NYC HEALTH INSURANCE PLANS**

Please sign and return the 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 premium payment / deduction. If your spouse / DP covers you under their health plan, then complete Sections I and III and attach your spouse's / DP's health insurance premium payment / deduction. 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 Alternate ID number: _____

Current Address: _____

Pension # _____ **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 2007:** \$ _____

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 spouse's / DP's health plan)

Spouse's / DP's Name: _____

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

Name of spouse'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 2007:** \$ _____

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

Member's Signature

Date