



**UFT WELFARE FUND**  
**52 BROADWAY, 7<sup>TH</sup> FLOOR, NEW YORK, NY 10004**

**RIDER CLAIM FORM – 2008 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 2008:** \$ \_\_\_\_\_

**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 2008:** \$ \_\_\_\_\_

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

\_\_\_\_\_  
**Member's Signature**

\_\_\_\_\_  
**Date**