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

RIDER CLAIM FORM – BENEFIT YEAR _____ *(fill in year)*
FOR NON-NYC HEALTH INSURANCE PLANS

This form only 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(s) or deduction(s) **for the entire period**. If your spouse/DP covers you under his/her health insurance /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-*last 5 digits* **or** UFTWF ID *full* Number _____

Current Address: _____ Email:_____

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 Jan-Dec: $_____

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 (last 5 digits):_____

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 Jan-Dec: $_____

_____ _____

Member's Signature **Date**