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

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

This form should only be completed if you are a UFT Welfare Fund Retiree and you or your spouse / domestic partner (DP) is paying for your NYC Health Plan coverage or NYC Optional Rider coverage through pension deduction/direct payment.

Please sign and return this form with the appropriate documentation to the UFT Welfare Fund. If you carry the health plan, please complete Section I and attach your pension stub/statement to the completed form. If your spouse/ domestic partner covers you under his/her city health plan, please complete both Section I and Section II and attach his/her city pension or payroll check stub/statement.

SECTION I

Member's Full Name: _____Telephone #:_____

Social Security Number-*last 5 digits* **or** UFTWF ID *full* Number _____

Current Address: _____ Email:_____

Which NYC pension system are you receiving your pension check from? _____

Retirement Date: _____

Which NYC health plan are you enrolled in? _____

Monthly Payment/Deduction: $_____ # of months paid: ____ Total Payment/Deduction for Jan-Dec: $_____

SECTION II **(**To be completed **only** when you are covered under your spouse / domestic partner's health plan)

Spouse's / Domestic Partner's Name: _____

Spouse's / DP Social Security Number (last 5 digits): _____
(or *full* WF-ID Number if also a UFT member)

To which NYC pension system does your spouse / domestic partner belong?

_____

Retirement Date (or write Active): _____ Indicate Single or Family Plan: _____

Monthly Payment/Deduction: $_____ # of months paid: ___ Total Payment/Deduction for Jan-Dec: $_____

_____ _____
Member's Signature **Date**