WELFARE FUND
52 Broadway
New York. NY 10004

2018
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 2018 5% Catastrophic Copayments, in excess of $5,000.00

☐ **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 2018 5% Catastrophic Copayments, in excess of $5,000.00

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

2- This Form, along with a copy of your Annual Prescription Statement (Explanation of Benefits), must be submitted to the UFT Welfare Fund for reimbursement **NO LATER** than February 1, 2019.

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 Also 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: 2018

Total Dollar Amount Of All Calendar Year 2018 5% Catastrophic Copayments, In Excess of $5,000.00, 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: _____