UFT
WELFARE FUND
52 Broadway
New York, NY 10004

2020
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 2020 5% Catastrophic Copayments, in excess of $6,350.00

☐ **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 2020 5% Catastrophic Copayments, in excess of $6,350.00

1- Member must complete Box A (below) with the required information for any claim being submitted (whether for the member and or 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, 2021.

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: 2020

Total Dollar Amount of All Calendar Year 2020 5% Catastrophic Copayments, In Excess of $6,350.00, 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: _____