



1199SEIU Greater New York Benefit Fund

PO Box 2661, New York, NY 10108-2661
(212) 541-9150 • www.1199SEIUBenefits.org

STATEMENT OF CLAIM FOR MEDICARE PART D REIMBURSEMENT

FILING CLAIMS FOR MEDICARE PART D PREMIUM REIMBURSEMENT

1. Claims can be filed as needed on a Monthly, Quarterly, Semi-Annual or Yearly basis
2. **Please include Proof of Payment, such as a copy of your payment voucher, cancelled check or Social Security Statement**
3. This benefit is limited to Greater New York eligible retirees* only
4. This is a member-only benefit

Please Print Clearly in Ink

Your Name _____ Birth Date _____ Tel. No. _____

Address _____

Is this a new address? Yes No

Your Health Benefit ID # _____

Check Mos. Paid

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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 Year 20 _____

Total Reimbursement of Premium Claimed \$ _____

Member's Signature _____ Date _____

DO NOT PRINT

Remarks

* Eligibility is based on years of service and age at retirement. Check your Summary Plan Description for details.