

AFL HOTEL AND RESTAURANT WORKERS TRUST FUNDS

560 North Nimitz Highway, Suite 209 • Honolulu, Hawaii 96817-5315 • Fax (808) 537-1074
 Phone (808) 523-0199 • Neighbor Islands Dial Direct 1 (866) 772-8989

**DRUG
PLAN (D)**

APPLICATION FOR OUT-OF-STATE PREMIUM REIMBURSEMENT

IMPORTANT: PLEASE COMPLETE ALL SECTIONS - This form cannot be processed if information is incomplete.

I hereby certify that I am enrolled in a Medicare Part D (Prescription Drug Plan) as outlined below:

Member Last Name		Member First Name		M.I.
Street Address		City	State	Zip Code
Social Security Number		Telephone Number	Carrier Name	
Coverage				
<input type="checkbox"/> 1 st Quarter 2022 (Jan – March)		<input type="checkbox"/> 3 rd Quarter 2022 (July – September)		
<input type="checkbox"/> 2 nd Quarter 2022 (April – June)		<input type="checkbox"/> 4 th Quarter 2022 (October – December)		

IMPORTANT NOTE:

- Member and Spouse must each submit a reimbursement form.

INSURANCE REIMBURSEMENT INFORMATION

Proof of payment (photocopy) included with this claim:	<input type="checkbox"/> Receipt from Insurance Carrier <input type="checkbox"/> Cancelled check <input type="checkbox"/> Money Order <input type="checkbox"/> Other (please specify) _____
Monthly Premium amount paid [cannot be greater than the total amount documented by the Proof of Payment provided]: <p style="text-align: center;">\$ _____</p>	

CERTIFICATION

By signing below, I acknowledge that I have been advised of the Medicare Reimbursement Benefits. I also understand that I must apply for this reimbursement. The Trust Fund Office will not make retroactive Medicare reimbursement payments. I certify that the foregoing information is accurate and complete and that I will provide other documentation as may be required in order to receive reimbursement.

SIGNATURE I have read, understand and agree to the terms and conditions on this form.

X _____
Retiree Signature Date Signed

TO BE COMPLETED BY TRUST FUND OFFICE			
	CURRENT PLAN	MAXIMUM REIMBURSEMENT	CHECK REQUEST
Monthly Premium:	\$	\$33.19 / Mo.	\$
# Months Reimbursed:	X 3 Months	X 3 Months	X 3 Months
Total Amount:		\$99.57	

Requested By: _____ Date: _____