

# AFL HOTEL AND RESTAURANT WORKERS TRUST FUNDS

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## APPLICATION FOR OUT-OF-STATE PREMIUM REIMBURSEMENT

### MEDICAL PLAN

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

**I hereby certify that I am enrolled in a Medicare (Medical 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 <sup>st</sup> Quarter 2026 (Jan – March)		<input type="checkbox"/> 3 <sup>rd</sup> Quarter 2026 (July – September)		
<input type="checkbox"/> 2 <sup>nd</sup> Quarter 2026 (April –June)		<input type="checkbox"/> 4 <sup>th</sup> Quarter 2026 (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
<b>Monthly Premium:</b>	\$	\$72.26 / Mo.	\$
<b># Months Reimbursed:</b>	X 3 Months	X 3 Months	X 3 Months
<b>Total Amount:</b>		\$216.78	

Requested By: \_\_\_\_\_ Date: \_\_\_\_\_