HAWAII TEAMSTERS HEALTH & WELFARE TRUST
Benefit and Risk Management Services
560 N. Nimitz Highway, Suite 209
Honolulu, HI 96817-5315

February 2009

TO: All OTS Retirees and Spouses Residing Out-of-State
Hawaii Teamsters Health and Welfare Trust

FROM: Board of Trustees

SUBJECT: RETIREES AND SPOUSES RESIDING OUT-OF-STATE
MEDICARE PART D REIMBURSEMENT POLICY FOR 2009

Effective January 1, 2009, the Medicare Part D Premium Reimbursement Policy for retirees and spouses residing out-of-state shall be as follows:

1. The Trust will reimburse the Medicare retiree and spouse, who resides outside the State of Hawaii, for their Medicare Part D premium in accordance to the Part D National Base Beneficiary Premium amount of ***up to*** $30.36 per month for 2009;

2. Reimbursement payments will be made on a quarterly basis;

3. You must complete an "Application for Out-of-State Medicare Part D Premium Reimbursement" form which is available from the Trust Office;

4. You must submit the proper documentation to the Trust Office which shall include the following:
   - A completed "Application for Out-of-State Medicare Part D Premium Reimbursement" form
   - A copy or description of the approved Medicare Prescription Drug Plan in which you are enrolled;
   - Confirmation of your enrollment in the Medicare Prescription Drug plan;
   - Proof of payment for your Medicare Part D premium (i.e., receipt from insurance carrier, copy of cancelled check or money order, etc.)

5. If proper documentation is not received by the Trust Office; no reimbursement payment will be made.

Enclosed, for your use, are copies of the "Application for Out-of-State Medicare Part D Premium Reimbursement" forms for 2009.

Should you have any questions regarding this matter or require additional reimbursement forms, please contact the Trust Office at 1(866) 772-8989. Thank you.

HAWAII TEAMSTERS HEALTH & WELFARE TRUST

560 North Nimitz Highway, Suite 209 ● Honolulu, Hawaii 96817-5315 ● Fax (808) 523-5933
Phone (808) 523-0199 ● Neighbor Islands Dial Direct 1 (866) 772-8989

APPLICATION FOR OUT-OF-STATE
MEDICARE PART D 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

☐ 1st Quarter 2009 (Jan – March)
☐ 2nd Quarter 2009 (April – June)
☐ 3rd Quarter 2009 (July – September)
☐ 4th Quarter 2009 (October – December)

IMPORTANT NOTE:

- Member and Spouse must each submit a reimbursement form.

INSURANCE REIMBURSEMENT INFORMATION

Proof of payment (photocopy) included with this claim:

- ❑ Receipt from Insurance Carrier
- ❑ Cancelled check
- ❑ Money Order
- ❑ Other (please specify)_____

Monthly Premium amount paid [cannot be greater than the total amount documented by the Proof of Payment provided]:

$_____

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:	$	$30.36 / Mo.	$
# Months Reimbursed:	X 3 Months	X 3 Months	X 3 Months
Total Amount:		$91.08	

Requested By: _____ Date: _____