

HAWAII TEAMSTERS HEALTH & WELFARE TRUST

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 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	<input type="checkbox"/> January 2026	<input type="checkbox"/> April 2026	<input type="checkbox"/> July 2026	<input type="checkbox"/> October 2026
	<input type="checkbox"/> February 2026	<input type="checkbox"/> May 2026	<input type="checkbox"/> August 2026	<input type="checkbox"/> November 2026
	<input type="checkbox"/> March 2026	<input type="checkbox"/> June 2026	<input type="checkbox"/> September 2026	<input type="checkbox"/> December 2026

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:	\$	\$36.78 / Mo.	\$
# Months Reimbursed:	X 1 Month	X 1 Month	X 1 Month
Total Amount:		\$36.78	

Requested By: _____ Date: _____