HAWAII TEAMSTERS HEALTH & WELFARE TRUST

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APPLICATION FOR OUT-OF-STATE
MEDICARE PART D PREMIUM REIMBURSEMENT

DRUG PLAN (D)

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

❑ January 2021	❑ April 2021	❑ July 2021	❑ October 2021
❑ February 2021	❑ May 2021	❑ August 2021	❑ November 2021
❑ March 2021	❑ June 2021	❑ September 2021	❑ December 2021

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:	$	$33.06 / Mo.	$
# Months Reimbursed:	X 1 Month	X 1 Month	X 1 Month
Total Amount:		$33.06	

Requested By: _____ Date: _____

Statute of limitation for Medicare Part D reimbursement should not exceed 12 months