HAWAII TEAMSTERS HEALTH & WELFARE TRUST

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APPLICATION FOR OUT-OF-STATE
MEDICAL 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

❑ January 2024 ❑ April 2024 ❑ July 2024 ❑ October 2024
❑ February 2024 ❑ May 2024 ❑ August 2024 ❑ November 2024
❑ March 2024 ❑ June 2024 ❑ September 2024 ❑ December 2024

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:	$	$39.71 / Mo.	$
# Months Reimbursed:	X 1 Month	X 1 Month	X 1 Month
Total Amount:		$39.71	

Requested By: _____ Date: _____

Statute of limitation for Medical reimbursement should not exceed 12 months