HAWAII TEAMSTERS HEALTH & WELFARE TRUST

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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
- ❑ 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:	$	$34.71 / Mo.	$
# Months Reimbursed:	X 1 Month	X 1 Month	X 1 Month
Total Amount:		$34.71	

Requested By: ______________________________ Date: ______________________

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