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 2018   ❑ April 2018   ❑ July 2018   ❑ October 2018
❑ February 2018   ❑ May 2018   ❑ August 2018   ❑ November 2018
❑ March 2018   ❑ June 2018   ❑ September 2018   ❑ December 2018

IMPORTANT NOTE:

- Member and Spouse must each submit a reimbursement form.

INSURANCE REIMBURSEMENT INFORMATION

Proof of payment (photocopy) included with this claim:
❑   <u>Receipt</u> 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:	$	$130.68 / Mo.	$
# Months Reimbursed:	X 1 Month	X 1 Month	X 1 Month
Total Amount:		$130.68	

Requested By: _____ Date: _____

Teamsters – Medical Out-of-State Reimbursement

Statute of limitation for Medical reimbursement should not exceed 12 months