# 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 2017 ❑ April 2017 ❑ July 2017 ❑ October 2017
❑ February 2017 ❑ May 2017 ❑ August 2017 ❑ November 2017
❑ March 2017 ❑ June 2017 ❑ September 2017 ❑ December 2017

**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:** | $ | $130.68/ Mo. | $ |
| **# Months Reimbursed:** | X 1 Month | X 1 Month | X 1 Month |
| **Total Amount:** | | $130.68 | |

Requested By: _____ Date: _____