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 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:	$	$35.63 / Mo.	$
# Months Reimbursed:	X 1 Month	X 1 Month	X 1 Month
Total Amount:		$35.63	

Requested By: _____ Date: _____