

# 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	<input type="checkbox"/> January 2019	<input type="checkbox"/> April 2019	<input type="checkbox"/> July 2019	<input type="checkbox"/> October 2019
	<input type="checkbox"/> February 2019	<input type="checkbox"/> May 2019	<input type="checkbox"/> August 2019	<input type="checkbox"/> November 2019
	<input type="checkbox"/> March 2019	<input type="checkbox"/> June 2019	<input type="checkbox"/> September 2019	<input type="checkbox"/> December 2019

**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) \_\_\_\_\_

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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** \_\_\_\_\_ Date Signed

Retiree Signature

TO BE COMPLETED BY TRUST FUND OFFICE			
	CURRENT PLAN	MAXIMUM REIMBURSEMENT	CHECK REQUEST
<b>Monthly Premium:</b>	\$	\$223.00 / Mo.	\$
<b># Months Reimbursed:</b>	X 1 Month	X 1 Month	X 1 Month
<b>Total Amount:</b>		\$223.00	

Requested By: \_\_\_\_\_ Date: \_\_\_\_\_