I.B.E.W. LOCAL 910 HEALTH AND WELFARE FUND
25001 Water Street, Watertown, New York 13601
Tel: (315) 782-5941, Fax: (315) 782-7343

MEDICARE PART D PREMIUM REIMBURSEMENT CLAIM FORM

CLAIMANT DATA **SECTION 1**

Participant Name: _____ Social Security#: _____

Participant's Address: _____ Date of Birth: _____

_____

Period of Reimbursement: _____

Individual (s) for whom documentation of reimbursable Part D premium is attached:

NAME:	RELATIONSHIP TO PARTICIPANT	DATE OF BIRTH
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____

DOCUMENTATION OF CLAIM **SECTION 2**

TOTAL REIMBURSEMENT APPLIED FOR: **$_____**

The participant must submit receipts documenting premiums paid for a Medicare Part D plan and this form to receive reimbursement.

I hereby certify that the information contained in this form is, to the best of my knowledge and belief, true and accurate, and is eligible for reimbursement.
The Trustees, or the designee, have sole and absolute discretion to determine whether the expenses submitted are eligible for reimbursement.

_____ Date: _____
Signature of participant submitting reimbursement form