



1199SEIU National Benefit Fund

330 West 42nd Street, New York, NY 10036-6977 • www.1199SEIUBenefits.org

Tel (646) 473-8666 • Outside NYC Area Codes: (800) 575-7771

Statement of Claim for Medicare Part D Reimbursement

1. Claims can be filed as needed on a monthly, quarterly, semi-annual or annual basis.
2. Please include proof of payment, such as a copy of your payment voucher, canceled check or Social Security statement.

Please Print Clearly in Black or Blue Ink

Member's full name: _____

Date of birth: ____/____/____
Month Date Year

Telephone: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Is this a new address? Yes No

Member ID: _____

Check box(es) for months paid

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Year 20_____

Total reimbursement of premium claimed: \$ _____

Member's signature **X** _____ Date: _____

Please complete form and return it to:
 1199SEIU National Benefit Fund
 PO Box 2661
 New York, NY 10108-2661