1199SEIU Greater New York Benefit Fund

PO Box 2661, New York, NY 10108-2661 • Tel: (646) 473-8666 • Outside NYC (800) 575-7771 • www.1199SEIUBenefits.org • @1199SEIUBenefits

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.
3. This benefit is limited to Greater New York eligible retirees only.
4. This is a member-only benefit.

Please print clearly in black or blue ink or complete online.

MEMBER'S FULL NAME (FIRST AND LAST NAME)

DATE OF BIRTH (MM/DD/YY) **PRIMARY PHONE**

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

Year 20_____

Total Reimbursement of premium claimed: $ _____

X _____

MEMBER'S SIGNATURE **DATE (MM/DD/YYYY)**

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