1199SEIU National 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.

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 National Benefit Fund
PO Box 2661
New York, NY 10108-2661