YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

2729 Crompond Road
Yorktown Heights, NY 10598
914-962-7442

MEDICAL PREMIUM REIMBURSEMENT BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20______

To be eligible for this benefit, ***you must have had incentive monies deposited on your behalf***, into the Fund, by the Board of Education. You are eligible for a reimbursement of ***medical premium expenses*** incurred during the ***calendar year***. This benefit may be claimed only once each year, after the fourth quarterly payment for medical premiums has been paid to the Yorktown School District. You must furnish copies of your paid premium notices for the calendar year being claimed. This benefit ceases when the incentive monies and accrued interest have been paid out to the member or covered survivor.

NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE YEAR IN WHICH SUCH MEDICAL PREMIUM EXPENSES WERE INCURRED.

MEMBER MUST COMPLETE THIS SECTION

NAME OF MEMBER

BUILDING ASSIGNMENT | JOB CATEGORY | AMOUNT CLAIMED

I understand that I am responsible for any expense not covered by this benefit.

Date: ________________ Member's Signature: ____

Retirees, *please provide current address that you want benefit mailed to:*

Name: ____

Address: ____

City: ________________________________ State: ______ Zip: __________

FOR TRUSTEE'S USE ONLY

DATE OF PAYMENT | CHECK# | AMOUNT PAID

CLAIMS MAY BE SENT VIA INTERSCHOOL MAIL TO YCT WELFARE FUND IN BUILDING B