YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

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

PRESCRIPTION DRUG CO-PAY BENEFIT

STATEMENT OF CLAIM FOR THE YEAR **20**______

To receive your prescription drug co-pay benefit reimbursement incurred by our member or eligible dependent, you must submit drug co-pay receipts, dispensed by a licensed pharmacist, which indicate name of patient, date of purchase, prescription #, name of the drug, total charges and the amount of co-pay paid by the patient. No credit card receipts are acceptable. If both adults have drug coverage, appropriate evidence of co-ordination must be presented to the Fund.

You may submit a claim for this benefit only once per year. This benefit is subject to a deductible. Payment will be made only in compliance with Fund rules.

NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE YEAR IN WHICH SUCH PRESCRIPTION DRUG 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 TRUSTEES USE ONLY

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DATE OF PAYMENT CHECK# AMOUNT PAID

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