East Williston Teachers' Association Benefit Fund

Prescription Drug Co-Pay Benefit Claim Form

RETURN THIS FORM TO
East Williston Teachers' Association Benefit Fund
253 West 35th Street, 12th Floor
New York, NY 10001
(800) DHCOOK1

MEMBER NAME (print last name first)	Sex ☐ M ☐ F	MEMBER'S SOCIAL SECURITY NUMBER | |	MEMBER DATE OF BIRTH MO. DY. YR.

HOME ADDRESS Number and Street APT.	HOME PHONE (include area code)

CITY STATE ZIP	PAYROLL TITLE	EMPLOYER PHONE (include area code)

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO

IF "YES", GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER AND SPOUSE'S SOCIAL SECURITY NUMBER.

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER SIGN HERE _____ Date ____

Member claiming for self and eligible dependents is eligible for this benefit.

The Fund reimburses the member up to a maximum of $250 for prescription drug co-payments paid for prescriptions provided to the member and/or the member's eligible dependent under their Empire Medical Plan Coverage.

Obtain a Prescription Drug Co-pay Benefit claim form from the main offices of each building or from the Fund Office. PHARMACY DRUG PRINTOUTS MUST BE ATTACHED TO THE CLAIM FORM. THE PATIENTS NAME, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF DRUG, PRESCRIBING DOCTOR'S NAME, DISPENSING PHARMACY AND THE COST, OR CO-PAYMENT AMOUNT, OF THE PRESCRIPTION TO THE PATIENT IS ENTERED. THE CO-PAYMENT AMOUNT MUST BE INDICATED EITHER ON THE CLAIM FORM OR THE PHARMACYS PRINT-OUT. All items listed will be subject to verification.

Please submit your claim once the total amount of co-payments ($250) has been reached or if not reached once the current calendar year has ended. All claims must be received no later than 3/31 of the following year the co-payment was incurred.

Prescription Drug Claim may only be submitted once ANNUALLY.

Note: The same rules and regulations governing your primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If for some reason you had to pay full price for a prescription (perhaps your card was unavailable, or you were out-of-state), you MUST first submit the costs to your primary prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions at a later date will NOT be reconsidered for payment.