YONKERS FEDERATION OF TEACHERS WELFARE FUND

c/o Daniel H. Cook Associates Inc.

1040 Avenue of the Americas, 24th FL, New York, NY 10018

(914) 250-0700

STATEMENT OF CLAIM FOR PRESCRIPTION DRUG BENEFIT

FOR MEMBERS UNDER EMPIRE PLAN OPTION:

Effective January 2005, for those members who have elected coverage under the Empire Plan, the reimbursement for prescriptions is $15.00 per prescription, with the exception of prescriptions filled for 90 days. These prescriptions will be paid up to $45.00.

FOR OTHER COVERED MEMBERS:

The Fund pays the cost of prescription drugs as follows: After a single member meets a $100 annual deductible or $200 family annual deductible, the Fund will pay $50 of the deductible and 20% of the cost of covered prescription drugs over the $50.

THE MAXIMUM YEARLY BENFIT IS $1,500 PER YEAR PER FAMILY.

Attach either a computer print-out form from the pharmacy or the original paid receipts to this claim form. Each bill must show the patient's name, date of purchase, prescription number, name of drug, cost and prescribing doctor's name. The pharmacy name, address and phone number must be provided.

YOUR CLAIM MUST BE IN DANIEL H. COOK'S OFFICE OR POSTMARKED NO LATER THAN MARCH 31st FOLLOWING THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSE WAS INCURRED.

PRESCRIPTION DRUG CLAIM FORMS WILL ONLY BE ACCEPTED ONCE A YEAR. TO OBTAIN MAXIMUM BENEFITS, CLAIMS SHOULD BE SUBMITTED IN ACCORDANCE WITH THE RULES OUTLINED ABOVE.

ONE FORM PER FAMILY – MEMBER MUST COMPLETE THIS SECTION

Member's Name:	Social Security Number:	Date of Birth:
Home Address City State Zip Code		Home Phone

Name of School or Building Assignment:	Date of Employment in Yonkers System:	This Claim is For: ☐ Member Only ☐ Family	Amount Claimed:

I am covered by the NYS Government Employees Health Plan

☐ Empire Plan Option ☐ HMO ☐ Other (Please Indicate) _____

I certify that no other health plan, insurance company or other coverage has paid the cost of the prescription(s) for which I have claimed reimbursement from the Yonkers Federation of Teachers Welfare Fund on this form.

I acknowledge that the statements made by me on this form are made to induce the Fund to provide benefits to me and that the Fund will rely on the Truthfulness of said statements. I hereby affirm that said statements are true, under the penalty of perjury, and I hereby agree indemnify and make whole the Fund, its successors and/or assigns against any and all liability and/or loss arising out of the payment of provision of said benefits to me as a result of my providing any false or misleading information to or the concealment of any pertinent material information from the fund.

Date _____ Member's Signature_____

FOR ADMINISTRATOR ONLY

MEMBER/DEPENDENT	AMOUNT PAID $_____	FOR YEAR _____