

**SEIU LOCAL 300 CIVIL SERVICE FORUM
RETIRED EMPLOYEES WELFARE FUND**
www.seiulocal300.org

**NOTIFICATION AND ENROLLMENT APPLICATION
FOR MEDICARE PART D PREMIUM REIMBURSEMENT BENEFIT**

NOTIFICATION

If you (and your covered spouse) enroll in a Medicare Part D prescription drug plan, starting in January 2026, you will be eligible to enroll in the SEIU Local 300 Civil Service Forum Retired Employees Welfare Fund's new Medicare Part D Premium Reimbursement Program. This program will reimburse Medicare eligible retirees and their Medicare eligible spouses each up to **\$300** per year for their Medicare Part D premium costs.

You must complete the attached application and return it to the Fund by no later than February 28, 2026 to notify the Fund that you have enrolled in a Medicare Part D prescription drug plan and qualify for the premium reimbursement benefit for 2026.

Attach a copy of your Medicare card or other proof that you have Part D prescription drug coverage to this application. Once you submit this application, you will be enrolled in the Fund's Medicare Part D Premium Reimbursement Program and will **not** have to resubmit an application every year.

Note - Once you enroll in a Medicare Part D prescription drug plan, it will be your primary and only prescription drug coverage. You will no longer be eligible for the Fund's prescription drug coverage. Your other benefits will not change.

Reimbursement will occur in the spring of the year, following the close of the year in which you paid Medicare Part D premiums. For example, up to \$300 in Medicare Part D premiums you paid in 2026, would be reimbursed to you in Spring 2027.

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ENROLLMENT APPLICATION

Section I: Retiree Information: YOU **MUST** PROVIDE A COPY OF YOUR MEDICARE CARD OR OTHER PROOF THAT YOU HAVE MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Name (Last, First, MI): _____ Social Security Number: _____

Retirement Date: _____ : Phone Number: _____

Date of Birth: _____ Address: _____

City/State/Zip: _____

Name of Medicare Prescription Drug Plan: _____

Section II: Eligible Spouse Information: YOU **MUST** PROVIDE A COPY OF YOUR SPOUSE'S MEDICARE CARD OR OTHER PROOF THAT YOU HAVE MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Name (Last, First, MI): _____ Social Security Number: _____

Retirement Date: _____ : Phone Number: _____

Date of Birth: _____ Address: _____

City State Zip: _____

Name of Medicare Prescription Drug Plan: _____

Please submit this form, along with a copy of applicable Medicare Card(s)

Electronically to:

OR

By mail to:



Eligibility.dept@dhcook.com



SEIU Local 300 Retired Employees Welfare Fund
1040 Avenue of the Americas, 24th Fl
New York, NY 10018

Questions? You can call our Customer Service Department at 212-505-5050, option 3