1199SEIU National Benefit Fund

330 West 42nd Street, New York, NY 10036-6977 • www.1199SEIUBenefits.org
Tel (646) 473-8666 • Outside NYC Area Codes: (800) 575-7771

Statement of Claim for Medicare Part D Reimbursement

1. Claims can be filed as needed on a monthly, quarterly, semi-annual or annual basis.
2. Please include proof of payment, such as a copy of your payment voucher, canceled check or Social Security statement.
3. This benefit is limited to National Benefit Fund eligible retirees only.
4. This is a member-only benefit.

Please Print Clearly in Black or Blue Ink

Member's full name: _____

Date of birth: _____/_____/_____ Telephone: (_____) _____
Month Date Year

Address: _____

City: _____ State: _____ Zip Code: _____

Is this a new address? ☐ Yes ☐ No

Member ID: _____

Check box(es) for months paid	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Year 20____

Total reimbursement of premium claimed: $ _____

Member's signature **X** _____ Date: _____

Please complete form and return it to:
1199SEIU National Benefit Fund
PO Box 2661
New York, NY 10108-2661