# AFL HOTEL AND RESTAURANT WORKERS TRUST FUNDS

560 North Nimitz Highway, Suite 209 ● Honolulu, Hawaii 96817-5315 ● Fax (808) 537-1074
Phone (808) 523-0199 ● Neighbor Islands Dial Direct 1 (866) 772-8989

APPLICATION FOR OUT-OF-STATE
PREMIUM REIMBURSEMENT

**MEDICAL PLAN**

**IMPORTANT: PLEASE COMPLETE ALL SECTIONS** - This form cannot be processed if information is incomplete.

## I hereby certify that I am enrolled in a Medicare (Medical Plan) as outlined below:

| Member Last Name | Member First Name | M.I. |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Social Security Number | Telephone Number | Carrier Name |
|---|---|---|
| | | |

Coverage

☐ 1st Quarter 2025 (Jan – March)
☐ 2nd Quarter 2025 (April –June)
☐ 3rd Quarter 2025 (July – September)
☐ 4th Quarter 2025 (October – December)

## IMPORTANT NOTE:

- Member and Spouse must each submit a reimbursement form.

## INSURANCE REIMBURSEMENT INFORMATION

Proof of payment (photocopy) included with this claim:

- ❑ Receipt from Insurance Carrier
- ❑ Cancelled check
- ❑ Money Order
- ❑ Other (please specify)_____

Monthly Premium amount paid [cannot be greater than the total amount documented by the Proof of Payment provided]:

$_____

## CERTIFICATION

By signing below, I acknowledge that I have been advised of the Medicare Reimbursement Benefits. I also understand that I must apply for this reimbursement. The Trust Fund Office will not make retroactive Medicare reimbursement payments. I certify that the foregoing information is accurate and complete and that I will provide other documentation as may be required in order to receive reimbursement.

## SIGNATURE I have read, understand and agree to the terms and conditions on this form.

X_____

Retiree Signature Date Signed

| TO BE COMPLETED BY TRUST FUND OFFICE | | | |
|---|---|---|---|
| | **CURRENT PLAN** | **MAXIMUM REIMBURSEMENT** | **CHECK REQUEST** |
| **Monthly Premium:** | $ | $72.26 / Mo. | $ |
| **# Months Reimbursed:** | X 3 Months | X 3 Months | X 3 Months |
| **Total Amount:** | | $216.78 | |

Requested By: _____ Date: _____



***Statute of limitation for Medical reimbursement should not exceed 12 months***