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

DRUG PLAN (D)

APPLICATION FOR OUT-OF-STATE
PREMIUM REIMBURSEMENT

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

I hereby certify that I am enrolled in a Medicare Part D (Prescription Drug 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:	$	$36.78 / Mo.	$
# Months Reimbursed:	X 3 Months	X 3 Months	X 3 Months
Total Amount:		$110.34	

Requested By: _____ Date: _____

Statute of limitation for Part D Medicare reimbursement should not exceed 12 months