DIVISION 1181 A.T.U. – NEW YORK WELFARE FUND
20 North Central Avenue, 3rd Floor, Valley Stream, N.Y. 11580
(718) 845-5800

December 2020

XXXX
XXXX
XXXX
XXXX

Re: Reimbursement of Prescription Benefit
Through a Premium-Based Program

Dear :

In 2010 Local 1181-1061 Amalgamated Transit Union had negotiated in the Collective Bargaining Agreement (CBA), an additional benefit for eligible Medicare Retirees. This benefit is for all Medicare eligible Retirees that are eligible for benefits under the Division 1181 A.T.U. – New York Welfare Fund and who have coverage from an Insurance Provider for a Medicare Part D Program and/or a Premium-Based Prescription Plan. If you fit into this category, you are entitled to a reimbursement of $25.00 per month for each month you have this coverage.

If your spouse has an independent Medicare Part D Program or Premium-Based Program, then they would also be entitled to the $25.00 per month reimbursement for each month they have coverage.

We are enclosing an Annual Certification Form that will need to be completed, notarized and sent back to the Fund Office in order to either continue to receive this benefit or to start this benefit. If we do not receive this completed form, you will not be entitled to this reimbursement. If you are currently receiving this benefit, kindly send this form back as soon as possible so there is no disruption in your receiving this benefit. We will need to have the form returned back to the Fund Office by January 22, 2021.

If you have any questions, please call Andrea, Ext. 322, at the Fund Office.

Very truly yours,

Robert D'Ulisse

Robert D' Ulisse
Director

enc.

ANNUAL CERTIFICATION OF A MEDICARE PART D PRESCRIPTION PROGRAM AND/OR PREMIUM BASED PRESCRIPTION PROGRAM

Name: _____ Social Security No: _____

☐ I have Medicare Part D effective _____.

☐ My spouse has Medicare Part D effective _____.

(Please attach a copy of your card/cards.)

☐ I have a Prescription Plan (other than Medicare Part D) for which I pay a monthly premium, effective _____.

☐ My spouse has a Prescription Plan (other than Medicare Part D) for which he/she pays a monthly premium, effective _____.

(Please attach a copy of your card/cards.)

☐ My spouse and I are both covered under a Prescription Plan (other than Medicare Part D) for which I pay a monthly premium, effective _____.

☐ My spouse and I are both covered under a Prescription Plan (other than Medicare Part D) for which he/she pays a monthly premium, effective _____.

(Please attach a copy of your card/cards along with proof that you or your spouse pay a monthly premium. Please submit the latest payment and the effective date of policy)

☐ I do not have Medicare Part D or another Prescription Plan for which I pay a monthly premium.

☐ My spouse does not have Medicare Part D or another Prescription Plan for which he/she pays a monthly premium.

ANNUAL CERTIFICATION OF A MEDICARE PART D PRESCRIPTION PROGRAM AND/OR PREMIUM BASED PRESCRIPTION PROGRAM

☐ I no longer have coverage from Medicare Part D – the policy terminated _____.

☐ My spouse no longer has coverage from Medicare Part D – the policy terminated _____.

☐ I no longer have coverage from another Prescription Plan for which I paid a premium – the policy terminated _____.

☐ My spouse no longer has coverage from another Prescription Plan for which he/she paid a premium – the policy terminated _____.

***Please note that if you enroll in Medicare Part D or any other premium based prescription plan in the future, you may still send us a copy of your card.**

_____ _____

Participant Signature **Date**

Sworn and subscribed to before me this _____ day of _____, 20__.

_____ **My commission expires:** _____

Notary Public