

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

December 2025

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, and sent back to the Fund Office in order to either continue to receive this benefit or to start this benefit. You can return the completed form by email (the address is: MedicareRX@Local1181ATU.com), fax (718) 323-3836, or by mail. 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 16, 2026.

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

Very truly yours,



Robert D' Ulisse
Director

enc.

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

Name: _____ Social Security No: _____

Part A - Pensioner (Self): This Section is to be completed by Retiree

I have Medicare Part D or a comparable Prescription Plan for which I pay a monthly premium, effective _____.

(Please attach a copy of your Rx card. If you have a Prescription Plan other than Medicare Part D, kindly attach proof that you pay a monthly premium. Please submit the latest payment and the effective date of policy.)

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

I no longer have coverage from Medicare Part D or a comparable Prescription Plan for which I pay a monthly premium– the policy has terminated _____.

Part B - Your Spouse: This section is to be completed for your spouse

Complete **ONLY** if you are married, and your spouse does not collect their own pension benefit from Division 1181 N.Y. Employees Pension Fund.

My spouse has Medicare Part D or a comparable Prescription Plan for which he/she pays a monthly premium, effective _____.

(Please attach a copy of your spouse's Rx card. If your spouse has a Prescription Plan other than Medicare Part D, kindly attach proof that he/she pays a monthly premium. Please submit the latest payment and the effective date of policy.)

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

My spouse no longer has coverage from Medicare Part D or a comparable Prescription Plan for which he/she pays a monthly premium – the policy has terminated _____.

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

Participant Signature

Date