RETIREE

GREAT NECK TEACHERS ASSOCIATION
BENEFIT TRUST FUND
PRESCRIPTION DRUG CLAIM FORM

MAIL CLAIMS TO:
THE PREFERRED GROUP
PO BOX 15136
ALBANY, NY 12212
HELP LINE:(866) 989-8997
FAX (866) 539-1394

Member's Last Name	Member's First name	Initial	Date Employed
Member: Mailing Address Number and Street			Social Security Number **XXX–XX–**___ ___ ___ ___
City	State	Zip Code	Phone Number ( )

Submit pharmacy printouts indicating the patient's name, date of purchase, prescription number, name of drug, prescribing doctor's name, dispensing pharmacy and the cost of the prescription to the patient. The benefit will pay co-payments to $250, with an additional $1.00 per co-payment per calendar year for all pharmacy co-payments incurred.

TOTAL AMOUNT MUST BE ENTERED TO RECEIVE PAYMENT $_____

I CERTIFY THAT THE ABOVE CHARGES WERE FOR THE BENEFIT OF MY ELIGIBLE FAMILY MEMBERS LISTED. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING THESE PRESCRIPTIONS TO THE BENEFIT FUND OR THEIR REPRESENTATIVES FOR PURPOSE OF AUDIT OR VERIFICATION.

MEMBER SIGNATURE: _____ DATE: _____

Prescription drug claim can ONLY BE SUBMITTED ONCE A YEAR for this benefit. All claims must be submitted by March 31st of the following year. If you are filing for this benefit prior to Dec 31, please initial here ____. No additional Prescriptions will be considered once you have filed for reimbursement.

WHO IS ELIGIBLE:

Member claiming for self and/or dependents

WHAT IS THE BENEFIT:

Once annually. Fund reimburses to a member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Prescription must be dispensed by a licensed pharmacist.

Prescription services which are covered are those under your primary prescription plan.

RESTRICTIONS:

- Only one claim per year per family is eligible
- Individual prescriptions MUST be accompanied by a pharmacy printout. Do not submit original receipts. The fund is not responsible for loss if originals are submitted.
- The Fund prescription drug coverage is secondary to your prescription drug coverage.

NOTE: The same rules and regulations governing your primary prescription drug plan apply. The fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If you had to pay full price for a prescription, you MUST first submit the cost to your pharmacy prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions at a later date will NOT be reconsidered for payment.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTUAL MATERIAL, THERETO, COMMITS A FRAUD, WHICH IS A CRIME.