WESTCHESTER C.O.B.A. WELFARE TRUST FUND
Co-Pay/Prescription Reimbursement Claim Form

MEMBER NAME: (print last name first)		ACTIVE ☐	RETIREE ☐
HOME ADDRESS: Number & Street	Apt #	Contact Phone #	
CITY	STATE	ZIP	

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER
SIGN HERE_____ **DATE**_____

Valid **proof of** payment must be provided in order to be reimbursed. Please include copies of co-pay/prescription receipts, prescription printout from your pharmacy, DR/ER visit printout that shows payment(s) made, copy of bank/credit card statements or copy of canceled check as proof of payment. **Explanation of Benefits (EOB) from your insurance carrier is NOT acceptable as proof of payment.**

CLAIMS WILL ONLY BE PROCESSED FROM FEBRUARY 1, 2024 THROUGH FEBRUARY 29, 2024
CLAIMS POSTMARKED AFTER FEBRUARY 29, 2024 WILL NOT BE CONSIDERED.
REIMBURSEMENT MAXIMUM $300 PER MEMBER

	DATE	EXPENSE	AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
		TOTAL AMOUNT	

Use reverse side for added submissions

PLEASE RETURN FORM TO:

WESTCHESTER C.O.B.A. WELFARE TRUST FUND
P.O. BOX 231
THORNWOOD, NEW YORK 10594
(914) 773-0436 PHONE (914) 773-0439 FAX
WCOBAWELFAREFUND@WESTCHESTERCOBA.ORG

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	DATE	EXPENSE	AMOUNT
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
		TOTAL AMOUNT	

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