



PSC CUNY Welfare Fund

P.O. Box 280278
Brooklyn, NY 11228
Phone: 212-354-5230 www.pscunywf.org

Prescription Reimbursement Form

File within 90 Days of Services

Member	
Last Name _____	First Name _____
Street Address _____	
City _____	State _____ Zip Code _____
Social Security Number _____	
Retiree of (College) _____	
Claim Filed for :	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Joint Submission [Both]
Please Check One:	<input type="checkbox"/> Application to Reimburse for Rx Rider <i>Attach Proof e.g., Pension Pay Stub</i>
	<input type="checkbox"/> Application to Reimburse for Rx Expenses <i>Attach Proof e.g. Receipts or Pharmacy Print-out</i>
Amount Claimed: \$ _____	An amount must be entered.
Please Note	Reimbursement is limited to \$400 <u>per family</u> per year. Receipts or other attachments cannot be returned. Copy before sending if necessary.
Member Signature _____	Date _____
For Office Use Only	
Approved _____	Date _____