

**WARWICK VALLEY TEACHERS
PRESCRIPTION REIMBURSEMENT**

EMPLOYEE NAME: _____

CLAIM INFORMATION

NAME	DATE	AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL _____

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT AND SERVICES ARE NOT COVERED BY OTHER PLANS

SIGNATURE: _____

DATE: _____

**RETURN FORM TO:
THE PREFERRED GROUP
P.O. BOX 15136
ALBANY, NY 12212-5136
(518) 641-0321 / 800-573-7474 / FAX 518-641-0325**