WARWICK VALLEY TEACHERS

PRESCRIPTION & MEDICAL CO-PAY REIMBURSEMENT

Employee name: ____

Claim information

Name	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