WARWICK VALLEY TEACHERS

PRESCRIPTION & MEDICAL CO-PAY REIMBURSEMENT

Employee Name: _____

Plan benefit: $125 per family per calendar year

Claim Information

Prescription Co-pay: _____

Medical Co-pay: _____

Total: _____

*Please attach all receipts

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

SIGNATURE: _____

DATE: _____

RETURN FORM BY MARCH 31 TO:

The Preferred Group

P.O. Box 15136

Albany, NY 12212-5136

(518) 641-0321 / 800-573-7474 / FAX: 518-641-0325