WARWICK VALLEY TEACHERS

PRESCRIPTION & MEDICAL CO-PAY REIMBURSEMENT

Employee Name: _____

Plan benefit: $175 per family per calendar year

Claim Information

Total Amount

_____**Prescription Co Pay**_____ _____

_____**Medical Co Pay** _____ _____

***Additional dental, vision, hearing expense (not covered by the plan)**_____

*maximum $25

Total (up to $175): _____

*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
Email to: claims@tpgplans.com