WARWICK VALLEY TEACHERS

PRESCRIPTION & MEDICAL CO-PAY REIMBURSEMENT

Employee Name: ____

Plan benefit: $150 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 $150): ____________________

*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