PRESCRIPTION CLAIM FORM

MAIL CLAIMS TO:
Faculty Association Suffolk Community College
Benefit Fund
253 West 35th Street – 12tth Floor
New York, NY 10001-1907
(212) 505-5050

ADMINISTRATIVE USE ONLY

CLAIM #

RETURNED FOR:

MEMBER FIRST MIDDLE LAST	DATE EMPLOYED	BARGAINING UNIT FA GUILD OTHER
MEMBER MAILING ADDRESS		
CITY, STATE, ZIP		Active Enhanced Plan Retiree
HOME PHONE ( ) WORK PHONE ( )		

TOTAL AMOUNT *MUST* BE ENTERED TO RECEIVE PAYMENT.

TOTAL AMOUNT

(*ATTACH PHARMACY PRINTOUT* FOR EACH ELIGIBLE FAMILY MEMBER)

Prescription Drug Copayment Benefit

Effective with prescriptions filled and paid for on and after January 1, 2014, the Fund will reimburse the copayment incurred by the member and or his/her eligible dependent, up to $500.00 per calendar year (an increase from $450.00!) **PLUS we will be paying** an additional 1% (one percent) of all the copayment per e