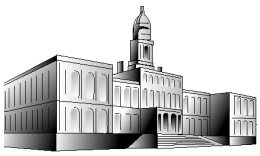
Management Benefits Fund (MBF)

SUPERIMPOSED MAJOR MEDICAL PLAN (SMMP)

ANNUAL MEDICARE PART D CATASTROPHIC COINSURANCE REIMBURSEMENT CLAIM FORM



I. CALENDAR YEAR REQUESTED: (A SEPARATE FORM MUST BE COMPLETED FOR EACH CALENDAR YEAR) 2 0 ____ ____

II. CHECK ONLY ONE: (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)

❑ MBF Member ❑ MBF Member Spouse/Domestic Partner

III. MEMBER INFORMATION:

Social Security No: ___-___-____	Date of Birth: __/__/____		
Last Name:	First Name:	M.I.:	
Address:	Apt:		
City:	State:	Zip Code:	
Home Telephone: ___-___-____	Work Telephone: ___-___-____		

IV. MBF SPOUSE/DOMESTIC PARTNER INFORMATION:

Social Security No: ___-___-____	Date of Birth: __/__/____		
Last Name:	First Name:	M.I.:	
Address:	Apt:		
City:	State:	Zip Code:	

Is spouse/domestic partner covered by another City Health Plan, or a separate Group Health Plan? ❑ Yes ❑ No

If yes, please list the name of other Group Health Plan and Certificate Policy Number below

Group Health Plan Name:

Certificate Policy Number:

V. CATASTROPHIC COINSURANCE:

Total Amount of 5% catastrophic coinsurance for the calendar year requested above in excess of the catastrophic coverage limit, as indicated on your prescription drug plan's annual Explanation of Benefits (EOB) statement (you must attach the EOB to this form):

$

VI. ACKNOWLEDGEMENT AND SIGNATURE:

I hereby apply for benefits and certify that the above information is complete, true and correct. I certify that I or my spouse/domestic partner have received the services attached. In the event that I receive an overpayment of benefits, on my behalf, or on behalf of my spouse/domestic partner, I am obligated to refund said overpayment to MBF immediately. I understand that any person who knowingly, and with intent to injure, defraud, or deceive any fund or insurance company, files a statement of claim containing false or misleading information, may be guilty of a criminal act punishable by law.

Member Signature:	Date: __/__/____
Spouse/Domestic Partner Signature:	Date: __/__/____

VII. INSTRUCTION FOR SUBMITTING CLAIMS:

1. Complete the above information and attach your annual Explanation of Benefits (EOB) that you receive from your prescription drug plan at the end of the year. This EOB indicates the 5% co-insurance that you paid out-of-pocket in excess of that year's maximum catastrophic coverage amount.
2. Submit claim form and EOB to:
   MBF SMMP Claims - Medicare Part D Reimbursement
   Administrative Services Only (ASO), Inc.
   PO Box 9009
   Lynbrook, NY 11563-9009
   Call toll free: (877) 844-SMMP (7667)

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