UNITED PROBATION OFFICERS ASSOCIATION
WELFARE FUND & RETIREMENT WELFARE FUND

2510 Westchester Ave., Suite 207 • Bronx, NY 10461 • P: 212.226.1069 • F: 917.398.1640

Please return completed, signed, and dated form, and supporting documentation, via mail to the above address or upload to www.asonet.com. All questions should be directed to the Fund at the above number. Save a copy of form and documentation for your records.

PRESCRIPTION DRUG BENEFIT (Member, Retiree, and Eligible Dependents)

The Welfare Fund will reimburse employees and retirees to the maximum benefit as described in the Summary Plan Description for the prescription drug expenses incurred annually by you and/or your eligible family members.
Claims must be submitted within one year of date of service.

WHAT DRUGS ARE COVERED: This benefit applies to prescription drugs and medications purchased from a licensed pharmacist. It does not cover drugs administered during hospitalization nor does it cover "over-the-counter" drugs, such as aspirin, cold tablets, cough syrup, etc. that may be bought without a doctor's prescription. Please note that most prescription drugs can be purchased under a generic brand name that has been proven to be effective and lower in cost. Please ask your doctor about substituting generic brands whenever possible.

HOW TO OBTAIN BENEFITS: Complete the Prescription Drug Benefit Claim Form below, and submit it along with an **original bill** (no fax copies) for each prescription, stating the following:

a. Date of purchase
b. Name of patient
c. Rx number, dosage, and name of drug
d. Name of prescribing doctor
e. Cost
f. Name and address of pharmacy

GENERAL INFORMATION

Member/Retiree Name _____
First Middle Last

Home Phone (with area code) _____ Cell Phone (with area code) _____

Address _____ _____ _____
Number Street City/Town

_____ _____ _____
State Zip Apt. No

Status: Employee ☐ Retiree ☐ Social Security Number _____

Date _____ Employee Signature _____

OFFICE USE ONLY

Claim # _____ Date _____

Denied ☐ Approved ☐ Amount paid _____

PRESCRIPTION DRUG BENEFIT

Please return completed, signed, and dated form, and supporting documentation, via mail to United Probation Officers Association Welfare Fund 2510 Westchester Ave, Suite 207, Bronx, NY 10461 or upload to www.asonet.com.

NOTE: The Fund Office will not return your drug bills. Cash register receipts will not be honored.

Date Purchased	Rx #	Drug Name	Physician Name	Cost
			TOTAL	$