TOWNSHIP OF MONROE
RETIREE MEDICAL/PRESCRIPTION REIMBURSEMENT CLAIM FORM

RETIREE INFORMATION				
NAME:	LAST	FIRST	MIDDLE	HOME PHONE NUMBER
ADDRESS:	STREET	APARTMENT#	CITY	STATE ZIP CODE
SS# / ID#:	AETNA SUBSCRIBER ID:			

DEPENDENT INFORMATION				
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP :
NAME:	LAST	FIRST	MIDDLE	RELATIONSHIP

INSTRUCTIONS

1) For Medical/Prescription Reimbursement Claims, attach copies of the Explanation of Benefits (EOB) issued by SNJ Health Fund AETNA ACPOS II $10 or $15 or AETNA Medicare Advantage Plan and/or Retail Pharmacy Customer Receipt, and/or Invoices or Claims & Balances Report to establish amount(s) paid and eligible for Plan Difference reimbursement.

2) Submit This Form To:
INSURANCE DESIGN ADMINISTRATORS
P.O. BOX 690
OAKLAND, NJ 07436
CUSTOMER SERVICE # - (800) 225-1345
FAX # - (201) 337-1391

EXPENSES

MEDICAL/PRESCRIPTION PROVIDER	DATE RANGE EXPENSES INCURRED	AMOUNT PAID	AMOUNT OF CLAIM
		TOTAL AMOUNT	$

A. I am submitting this Form with the required documentation, SNJ Health Fund AETNA ACPOS II $10 or $15 EOB, or AETNA Medicare Advantage Plan EOB, Proof of Payment and/or Retail Pharmacy Customer Receipt and/or Prescription Invoices or Claims & Balances Report.

RETIREE CERTIFICATION AND SIGNATURE

I Hereby Certify That:

1. The amount of the Claim is the difference between the current a SNJ Health Fund AETNA ACPOS II $10 or $15 EOB, or AETNA Medicare Advantage Plan EOB and your Prescription Drug "Claims and Balance" Report or receipts, whichever is applicable, and the prior Township of Monroe Plan, minus the Retiree responsibility, is owed to me, and

2. I have not received, and am not eligible to receive, any type of reimbursement or payment other than the amount noted as the difference in Plan provisions noted above, if any.

I CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

SIGNATURE_____ **DATE**_____