



**NEW YORK STATE
AUTOMOBILE DEALERS ASSOCIATION
GROUP INSURANCE TRUST**

2010 GIT Generic Reimbursement Claim Form

YOU MUST BE A MEMBER OF A GIT HEALTH PLAN TO BE ELIGIBLE !!!
(See guidelines for reimbursement of this alternate benefit)

Employee Name: _____

Employee Address: _____

Employee Social Security Number: _____

Employee phone: _____ Employee (cell) phone: _____

Employee Email (Optional): _____

Prescription for (check one): self spouse dependent (relationship) _____

Name of claimant checked above: _____

Indicate number of prescriptions attached/requested for reimbursement: _____

Employee signature: _____

Employee print name: _____

Date: _____ Dealer (employer) name: _____

Be sure to include copies of the prescription(s), and receipts for proof of purchase.

All claim reimbursement/claim submissions are to be sent to:

Group Insurance Trust

Attn: Generic Reimbursement Program

P.O. Box 7347

Albany, NY 12224-7347

No Faxes will be accepted!!!

Copies of Generic Reimbursement Guidelines and Additional Claim Forms are available on the NYSADA website (nysada.com) located on the GIT web page. You may contact us at 518-463-1148, ext. 311 (Kathy), or ext 312 (Mary). Additional claim forms available on nysada.com; please refer to the GIT web page.