

THE SDC-LEAGUE PENSION AND HEALTH FUNDS

1501 Broadway, 17th Floor
New York, NY 10036
Tel: 212-869-8129
Fax: 212-302-6195

PREMIUM REIMBURSEMENT VOUCHER

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE: _____ **EMAIL:** _____

INSURANCE COMPANY: _____

AMOUNT TO BE REIMBURSED: _____

FOR THE MONTH OF: _____

A copy of your premium bill must accompany this form. Reimbursement of the actual amount of your premium will be made up to a maximum of \$713.00 per month (effective 1/1/2012).