2017 Medicare
Part D Benefit

This application is for retired clergy and/or spouses of retired clergy from the Illinois Great Rivers Conference for expenses related to Medicare Part D Plans. **PASBF will not pay for any penalties.** The benefit is available for premiums, deductibles, and co-pays only.

This benefit may be stopped at any time. Beneficiaries will be notified prior to the stoppage of the benefit.

All information will be kept strictly confidential and only for the purposes of this application.

Name: ____

Address: ____

City, State, Zip Code: ____

Phone Number: ___________________________ Email: ____

Current Medicare Part D Plan(s): ____

- Member Number for Part D Plan: ____

Total Estimated Annual Cost for Medicare Part D Plan: _________________________________

Cost is for: ☐ Individual ☐ Couple

Amount I/we are requesting for assistance: $___________

Total Annual Income from the Previous Year: ______________

Please include all money received from all pension funds, annuities, employment, retirement accounts, and any other income.

Have you talked with your doctor regarding the cost of your medications? ☐ YES ☐ NO

- What recommendations did your doctor have?

  ____

  ____

  ____

Are any of your drugs included in any Pharmacy Discounts? ☐ YES ☐ NO

- Many large pharmacies offer significant discounts on some medications

What other ways have you tried to reduce your prescription drug costs?

____

____

OVER

Special Circumstances and/or Situation that we need to be aware of (such as medical bills/conditions, extra expenses, etc.): ____

____

____

Please return this form and a copy of:

1) **Most recent tax return (First 2 Pages)**
2) **Plan summary with the estimated cost**
3) **List of your medications along with dosage and frequency**

Preachers' Aid Society and Benefit Fund
PO Box 19207
Springfield IL 62794
217-529-3221
kanderson@igrc.org

PASBF Office Use Only

Date Application Received: __________

Application: ___ Approved ____ Denied

Date Approved/Denied: ____________

Amount of Assistance: _____________

How often is payment:

- ☐ Lump Sum
- ☐ Monthly

Which months:

How will payment be made:

- ☐ Payment directly to individual
- ☐ Payment to Plan:

Plan Name: ___________________________

Address: ______________________________

City, State, Zip: _______________________

Member Account Number: ________