PHILADELPHIA FEDERATION OF TEACHERS HEALTH AND WELFARE FUND
RETIREE BENEFIT APPLICATION

Last Name	**First**	**M.I.**	**Social Security #**
Home Address	**City**	**State/Zip**	**Phone#**
		M / F	
Date of Retirement	**Work Location**	**Gender**	**Date of Birth**

I am electing the following coverage(s):

☐ Prescription - Under 65

☐ Prescription - Over 65, Medicare Part D

☐ Vision

Please submit a copy of your medical/Medicare card. Members are permitted to have prescription coverage from **ONLY ONE SOURCE.**

Medicare Beneficiary Identifier Number (65 and older only)
_____

Personal Email Address: (REQUIRED)

_____**I give permission to use this email address for billing and other Fund communications.**

The data furnished by me on this application is accurate to the best of my knowledge. Late payments cannot be accepted. If I fail to make timely payments, I will be permanently terminated from the prescription and vision plans.

_____ _____
(Signature) (Date)

*Submit this application with a copy of your last statement of account from the Public School Employees Retirement system (PSERS) or a copy of your Disability Retirement Approval Letter. Your statement must show how many years of service you have. If you cannot locate either of these forms, please request a copy from PSERS at 215-443-3495.

Rev.10/2026