BENEFIT CLAIM FORM

MAIL CLAIM TO:
Dobbs Ferry United Teachers
DH Cook Associates, Inc
253 West 35th Street- 12th Floor, New York, New York 10001
(212) 505-5050

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT Self Spouse Child	SEX M F	PATIENTS BIRTHDAY - -
MEMBERS LAST NAME FIRST NAME			Subscriber ID - -
FULL MAILING ADDRESS NO. AND STREET		APT NO	HOME TELEPHONE NO ( ) -
CITY STATE ZIP	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? ☐ YES ☐ NO	IS THIS THE FIRST CLAIM FILED BY YOU? ☐ Yes ☐ No	
EMPLOYER	WORK TELEPHONE (INC. AREA CODE)	EXTENSION	
Is your your spouse Employed? ☐ Yes ☐ No	IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER		
ARE BENEFITS AVAILABLE FROM ANY OTHER GROUP INSURANCE CARRIER FOR THIS PATIENT? Yes No If "YES" SPOUSE BIRTHDATE _____MONTH _____DAY		MEMBERS BIRTHDATE Month Day Year	
I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AND AUTHOIRXZE RELEASE OF ANY INFORMAITON NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE MEMBER SIGN HERE _____DATE _____	BENEFITS ARE PAYABLE TO MEMBER ONLY		

CLAIMS FOR PRESCRIPTION AND MEDICAL REIMBURSEMENTS MUST BE SUBMITTED

AFTER JANUARY 1ST BUT NO LATER THAN MARCH 1ST

☐ ***Optical Benefit*** **(Family)**

This benefit provides up to $500.00 every two years per family beginning January 1, 2023 through December 31, 2024—this benefit is a two year cycle. Submissions should be made immediately after purchase.

☐ ***Prescription Benefit*** **(Family)**

This benefit provides co-payment and/or deductible reimbursement up to and including $250.00 with an additional 1% for all additional charges incurred during the calendar year, per family. Your prescription drug claim MUST be submitted no later than March 1ST of the following calendar year.

☐ ***Hearing Aid Benefit*** **(Member Only)**

This benefit provides up to and including $350.00 per member every 36 months.

☐ ***Medical Reimbursement Benefit*** **(Family)**

For each family, the Fund will reimburse $250.00 for the deductible, co-payment or out of pocket expenses with an additional 1% for all additional charges incurred during the calendar year, per family. Your medical claim MUST be submitted no later than March 1ST of the following calendar year.

ATTACH COPY OF STATEMENT FROM PHARMACEUTICAL, AND MEDICAL PROVIDER'S BILL SHOWING SERVICE DATES AND PAYMENT