MAIL BENEFIT CLAIM FORM TO:
Dobbs Ferry United Teachers
DH Cook Associates, Inc
1040 Avenue of the Americas, 24th Floor
New York, NY 10018
(800) DHCOOK1

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT Self Spouse Other 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 per year per family beginning January 1st through December 31st. Submissions should be made immediately after purchase.

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

This benefit provides co-payment and/or deductible reimbursement up to and including $300.00 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 $300.00 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