



# Smithtown Teachers' Association Benefit Fund

50 Route 111 • Suite 216 Smithtown, New York 11787 • 631 265 4218 • Fax 631 265 2926

## 2009 STATEMENT OF CLAIM

### NON-REIMBURSED MEDICAL/DENTAL/VISION FUND

MAXIMUM BENEFIT FOR CALENDAR YEAR 2009 is \$300.00 per member OR family members – NOT per member and each dependent in family

Please Print Legibly and Complete Form in full:

Insured Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

School building(s) \_\_\_\_\_

Home Address (Street) \_\_\_\_\_

(City/Town) \_\_\_\_\_

(State) \_\_\_\_\_ (Zip) \_\_\_\_\_ Home Tel: \_\_\_\_\_

Social Security No \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

#### COMPLETE ONLY IF YOUR CLAIM IS FOR A SPOUSE OR DOMESTIC PARTNER

Spouse/Partner Name \_\_\_\_\_

Spouse Social Security No \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

#### COMPLETE ONLY IF YOUR CLAIM IS FOR A DEPENDENT

Child Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

#### MAIL CLAIM FORM TO:

**Newman Company**

**925 Hempstead Turnpike, Suite 340, Franklin Square, NY 11010**

**NOTE:** This plan is intended to reimburse Medical/Dental/and Vision expenses. The purpose of this plan is to reimburse expenses otherwise not covered by another plan. In order to verify an expense is eligible for reimbursement from this plan, please include an Explanation of Benefits (EOB) showing that the claim was submitted to your insurance company and resulted in an out of pocket expense or "Patient Responsibility."

Claim forms for Office Visits for health, dental or vision must be accompanied by an Explanation of Benefits (EOB) from your insurance company showing "Patient Responsibility."

Claim forms for co-pays, including prescription copays, do not require an EOB but a receipt from the service provider must be submitted.

Any person who knowingly and with intent to defraud this company, who files a statement of claim containing any materially false information or conceals, for the purpose of misleading, any information may be subject to a civil penalty.

I certify that the above information given by me in support of this claim is true and correct.

I have enclosed the required documentation to support this claim.

Signed \_\_\_\_\_ Dated \_\_\_\_\_