Smithtown Teachers' Association Benefit Fund
26 New York Avenue • Smithtown, New York 11787 • Tel 631-265-4218 • Fax 631-265-2926

2020 STATEMENT OF CLAIM

NON-REIMBURSED MEDICAL/DENTAL/VISION FUND

NOTE: Maximum benefit for calendar year 2020 is $200.00 per member OR dependents – NOT per member and each dependent

◆ 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 _____

Child Name _____ Date of Birth _____

Child Name _____ Date of Birth _____

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.

By signing this form, you hereby satisfy that you are covered under the District's health insurance coverage, or by your spouse's employer provided health coverage. If you are requesting reimbursement for an expense of one of your eligible dependents, you also hereby certify that such dependent was covered by employer provided health coverage at the time such expense was incurred.

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_____