



# Smithtown Teachers' Association Benefit Fund

26 New York Avenue • Smithtown, New York 11787 • Tel 631-265-4218 • Fax 631-265-2926

## 2021 STATEMENT OF CLAIM NON-REIMBURSED MEDICAL/DENTAL/VISION FUND

**NOTE:** Maximum benefit for calendar year 2021 is **\$250.00** 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*

*Tel: 516-488-1100 Fax: 516-488-1110*

**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 \_\_\_\_\_