EAST WILLISTON TEACHERS ASSOCIATION
BENEFIT FUND

MEDICAL CO-PAYMENT REIMBURSEMENT BENEFIT

MEMBER PLEASE PRINT

Member's Last Name		Members First Name		Social Security No.
Full Mailing Address		Apt. No.	Home Telephone #	
I certify that the information given is correct and authorize release of any information necessary to process this claim.	Benefits are payable to Member only Member Sign here_________________________________Date__________			

ELIGIBLITY

Member claiming for self and eligible dependents.

BENEFIT DESCRIPTION

The Fund reimburses the member for participating provider major medical expenses paid for services to the member and/or the eligible dependent under their Empire Plan coverage up to $200.00 annually.

HOW TO FILE A CLAIM

Obtain a Medical Co-Payment Reimbursement Benefit claim form from the main offices of each building or from the Fund Office. The entire form must be completed in order to be eligible for payment. Explanation of Benefits forms (EOB's) from Empire Plan which show participating provider co-payments that you have paid for the calendar year must also be provided. All items listed will be subject to verification.

Please submit your claim once the total amount of co-payments ($200) has been reached or if not reached once the current calendar year has ended. All claims must be received no later than 3/31 of the following year for participating provider expenses.

Only one claim per year is eligible

Please submit your claim to:

East Williston Teachers Association
253 West 35th Street, 12th floor
New York, NY 10001