RETIREE EXCESS MEDICAL BENEFIT CLAIM FORM

MAIL CLAIM TO:

East Williston Teachers Association Benefit Trust Fund

253 West 35th Street- 12th Floor, New York, New York 10001

Tobi-Sue Janowitz (212) 505-5050 ext. 221

Patient's Name	Relationship to Member Self ☐ Spouse ☐ Child ☐ Other ☐	Sex ☐ M ☐ F	Patient's Date of Birth Month Day Year	Patient's Social Security Number - XXX - -XX- - -
Member's Last Name	First Name	Initial		Social Security # XXX - XX -- -
Full Mailing Address	No. and Street	Apt. No.		Home Phone ( ) -
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
Member's Classification (check one) ACTIVE _________ RETIREE________ COBRA__________				Member's Date of Birth Month Day Year
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", give name and carrier, plus name and LD. No. of subscriber				Spouse's Date of Birth Month Day Year
I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other group plan except as indicated above.	**BENEFITS ARE PAYABLE TO MEMBER ONLY** MEMBER SIGN HERE ____ DATE _______________			

Mark the benefit (s) for which you are applying: PLEASE ATTACH the explanation of benefits from the Empire Plan (United Health Care-Blue Cross), or any other group coverage along with applicable receipts and supporting documents. Claims must be submitted within 12 months from the date on your Explanation of Benefits.

EXCESS MEDICAL BENEFITS START HERE.

☐ **VISION CARE BENEFIT**
This benefit provides up to a maximum of $125 per insured person, based on the fee schedule once every year.
Claim must be submitted within 12 months from the most recent date of service.

☐ **OUT-PATIENT REHABILITATION BENEFIT***
This benefit is provides 50% of medical allowable for Occupational, Physical, Inhalation, Psycho diagnostic, Audio logical evaluation, Loan of rehab equipment.

☐ **IN-HOSPITAL CASH BENEFIT***
This benefit is provided for EMPLOYEE ONLY - $50/day, from the first day for as long as52 weeks.

☐ **IN-HOSPITAL PRIVATE DUTY NURSING BENEFIT***
This benefit provides 50% of the Usual and Customary charge for the first 48 hours of private duty nursing/hospitalized.

☐ **OUT OF NETWORK DEDUCTIBLE**
This benefit pay to a maximum of $1,000 of the annual deductible for members and eligible dependents

☐ **CO-INSURANSE REIMBURSEMENT BENEFIT ***
This benefit pays for the participant's 20% co-insurance portion of allowable expenses under the Empire Plan (United Health Care-Blue Cross) . Refer to the Summary of Benefits for specific details and exceptions.

☐ **NURSING HOME BENEFIT***
This benefit pays to a maximum of 30 days once all other insurance has been exhausted.