Manhasset Education Association Trust Fund
SUPPLEMENTAL BENEFIT CLAIM FORM
Effective 1/1/08

MEMBER PLEASE PRINT

Member's Last Name	Member's First Name		Member's Social Security No.
Full Mailing Address No. and Street		Apt. No.	Home Telephone #
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 ☐
Spouse's Last Name	First Name Initial		Spouse's Social Security No.
Member's Building	Member's Office Telephone No.		Member's Birthdate Mo. Day Year
Is 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 of carrier, plus name and I.D. No. of subscriber		
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_____		

Effective January 1, 2016, the Fund's supplemental benefit program will be expanded to cover children, in addition to members and spouses. Each family unit (including children) will be eligible to receive reimbursement of up to $400 per calendar year for dental and vision expenses. The Fund has decided to redirect monies to these expenses due to costly and onerous reporting obligations imposed by the Federal Patient Protection Affordable Care Act ("PPACA") on plans that provide medical benefits. Effective January 1, 2016, the Fund will temporarily suspend reimbursement for medical deductible, medical co-payment or prescription drug co-payment expenses while it continues to evaluate this situation.

Members may submit claims for this benefit only once per calendar year. Members must submit this claim form prior to April 30th of the calendar year following the year charges were incurred. For example, covered expenses incurred from 1/1/16-12/31/16 may be claimed from 1/1/17-4/30/17.

Attach to this claim form copies of the explanation or denial of benefits showing that you have expenses not reimbursed by any primary or secondary insurance plans. Mail completed forms to:

MEA TRUST FUND
C/O DANIEL H. COOK ASSOCIATES, INC.
253 WEST 35TH STREET, 12TH FLOOR
NEW YORK, NY 10001
(212) 505-5050