BENEFIT CLAIM FORM Dobbs Ferry United Teachers 253 West 35th Street, 12th Floor

New York, New York 10001

(800) DHCOOK1

TIENT'S NAME		RELATIONS SELF	SHIP TO PAR SPOUSE	TICIPANT CHILD						
	FIRST NAME				INITIAL	SOCIAL SECURITY NUMBER				
	NO. AND STREET					APT. NO.				
CITY	STATE ZIP CODE						HOME TELEPHONE NO.			
	D					FFERENT F	RENT FROM YOUR I YES FIRST CLAIM I YES			
IF "YES" GIVE NAME AN	ID ADDRESS OF Y	OUR SPOUSI	E'S EMPLOYI	ER						
							MEMBER'			
IF "YES", SPOUSE BIRT	MONTH DAY				AY	DAY				
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.				MEMBER					TE	
	IF "YES" GIVE NAME AN IF "YES", SPOUSE BIRT N GIVEN IS CORRECT AN ORMATION NECESSARY ARE NOT AVAILABLE UN	WORK TELEPHON IF "YES" GIVE NAME AND ADDRESS OF YO IF "YES", SPOUSE BIRTHDATE N GIVEN IS CORRECT AND ORMATION NECESSARY TO ARE NOT AVAILABLE UNDER ANY	SELF FIRST NAME NO. ANI CITY STAT WORK TELEPHONE NO (INCL IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSI IF "YES", SPOUSE BIRTHDATE N GIVEN IS CORRECT AND ORMATION NECESSARY TO ARE NOT AVAILABLE UNDER ANY	SELF SPOUSE FIRST NAME FIRST NAME NO. AND STREET CITY STATE WORK TELEPHONE NO (INCL AREA CODE) IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYI IF "YES", SPOUSE BIRTHDATE	FIRST NO. AND STREET CITY STATE WORK TELEPHONE NO (INCL AREA CODE) IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER IF "YES", SPOUSE BIRTHDATE MONTH ORMATION NECESSARY TO ARE NOT AVAILABLE UNDER ANY	SELF SPOUSE CHILD OTHER FIRST NAME FIRST NAME NO. AND STREET NO. AND STREET If CODE IS WORK TELEPHONE NO (INCL AREA CODE) IS IS IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER IF IF "YES", SPOUSE BIRTHDATE MONTH D N GIVEN IS CORRECT AND Benefits are pa ORMATION NECESSARY TO MEMBER	SELF SPOUSE CHILD OTHER M F FIRST INITIAL NO. AND STREET INITIAL CITY STATE ZIP CODE WORK TELEPHONE NO (INCL AREA CODE) IS THE ABOVE DIFFERENT FF LAST CLAIM F IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER IF "YES", SPOUSE BIRTHDATE MONTH DAY V GIVEN IS CORRECT AND ORMATION NECESSARY TO ARE NOT AVAILABLE UNDER ANY MEMBER	SELF SPOUSE CHILD OTHER M F FIRST INITIAL SOCIAL S NO. AND STREET APT. NO. CITY STATE ZIP CODE HOME TEI WORK TELEPHONE NO (INCL AREA CODE) IS THE ABOVE ADDRESS DIFFERENT FROM YOUR IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER IF "YES", SPOUSE BIRTHDATE MEMBER	SELF SPOUSE CHILD OTHER M F FIRST NITIAL SOCIAL SECURITY I NO. AND STREET APT. NO. CITY STATE ZIP CODE HOME TELEPHONE WORK TELEPHONE NO (INCL AREA CODE) IS THE ABOVE ADDRESS DIFFERENT FROM YOUR IYES IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER IMEMBER'S BIRTHD. IMEMBER'S BIRTHD. IF "YES", SPOUSE BIRTHDATE MONTH DAY MONTH	SELF SPOUSE CHILD OTHER M F FIRST INITIAL SOCIAL SECURITY NUMBER NO. AND STREET APT. NO. CITY STATE ZIP CODE HOME TELEPHONE NO. WORK TELEPHONE NO (INCL AREA CODE) IS THE ABOVE ADDRESS IS THIS THE IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER IS THE ABOVE ADDRESS IS THIS THE IF "YES", SPOUSE BIRTHDATE MONTH DAY MONTH

Use a separate form for each claim. Check appropriate box.

CLAIM MUST BE SUBMITTED WITHIN 180 DAYS AFTER SERVICES ARE RENDERED

Optical Benefit (Family)

This benefit provides up to \$400.00 every two years per family January through December 31, 2020.

Prescription Benefit (Family)

This benefit provides co-payment and/or deductible reimbursement up to and including \$250.00 with an additional 1% for all additional charges incurred during the calendar year, per family. Your prescription drug claim MUST be submitted no later than March 1st of the following calendar year. (Example: Covered expenses incurred from 1/1/18 through 12/31/18 can be claimed between 1/1/2019 and 2/28/2019).

□ *Hearing Aid Benefit* (Member Only)

This benefit provides up to \$350.00 per member once every 36 months.

□ *Medical Reimbursement Benefit* (Family)

This benefit pays 100% of a covered family's medical co-payment and deductible costs for services under his/her medical plan coverage up to \$250 every calendar year, and thereafter, up to 1% of all additional medical co-payments and deductible incurred during the same calendar year. The form must be submitted no later than March 1st of the following calendar year.

*ATTACH COPY OF STATEMENT FROM MEDICAL CARRIER AND PROVIDER'S BILL SHOWING SERVICE AND PAYMENT