BENEFIT CLAIM FORM

Dobbs Ferry United Teachers

253 West 35th Street, 12th Floor
New York, New York 10001
(800) DHCOOK1

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT SELF / SPOUSE / CHILD / OTHER	SEX M F	PATIENT BIRTHDATE

MEMBER'S LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER

FULL MAILING ADDRESS	NO. AND STREET	APT. NO.

CITY	STATE	ZIP CODE	HOME TELEPHONE NO.

EMPLOYER	WORK TELEPHONE NO (INCL AREA CODE)	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? ☐ YES ☐ NO	IS THIS THE FIRST CLAIM FILED BY YOU? ☐ YES ☐ NO

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", SPOUSE BIRTHDATE _____ MONTH _____ DAY	MEMBER'S BIRTHDATE _____ MONTH _____ 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.

Benefits are payable to member only.

MEMBER SIGN HERE _____ **DATE**

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**