New York State Court Clerks Association Security Benefits Fund

170 Duane Street, New York. NY 10013
Office: (212) 941-5700 Fax: (212) 941-5705
www.nyscourtclerks.org

Copay Benefit Claim Form
Retired

Effective 1/1/2023

Member's Last Name	Member's First Name			Member's SSN (last 4 digits)
Member's Mailing Address			Apt. No.	Member's Date of Birth MM / DD / YY
City	State	Zip	E-mail Address	Telephone No.

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's Signature: _____Date: _____

TOTAL AMOUNT: _____

This benefit provides reimbursement up to a maximum of $500 for the family for any combination of the eligible benefits listed below. This benefit reimburses out-of-pocket expenses for the members and dependents. Members may submit claims for this benefit only once per calendar year. You may claim your co-pay benefit at any point during the year at which you reach your benefit maximum. If you choose to wait, your claim MUST be submitted in the first month following the year charges were incurred in order to be eligible for coverage. (Example: Covered expenses incurred from 1/1/23 through 12/31/23 can be claimed between 1/1/23 and 01/31/24).

Mark {X} the benefit(s) for which you are applying:

☐ ***Co-Payment Reimbursement Benefit.***
The Fund will reimburse, up to the benefit maximum, the amount that the member has paid either as the deductible or the co-payment amount for their basic health coverage. A member must submit the explanation of benefits from their medical plan, which shows the deductible or co-payment portion that has been paid by the member for the calendar year. **2023 ONLY.**

☐ ***Prescription Benefit***
The Fund will reimburse a member for the co-payments per prescription, which have been paid within the calendar year up to the yearly maximum. If the prescription is not covered under your primary coverage, it is not covered under this plan. **2023 ONLY.**

☐ ***Health Insurance Reimbursement***
Health Insurance Reimbursement-The fund will reimburse a member for health insurance premiums which have been paid within the calendar year and up to the yearly maximum. **2023 ONLY.**

ATTACH COPIES OF ORIGINAL RECEIPTS TO THIS CLAIM FORM

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. *Email completed forms to intake@dhcook.com*
Mail completed forms to:

New York State Court Clerks Association
C/O DANIEL H. COOK ASSOCIATES, INC.
253 WEST 35TH STREET, 12TH FLOOR
NEW YORK, NY 10001
(212) 505-5050

The State of New York requires this statement to appear on all claims forms:
"Any person who knowingly and with the intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation." Fraudulent insurance acts are a crime in all states, and additionally a felony in several states.