YONKERS FEDERATION OF TEACHERS WELFARE FUND

c/o Daniel H. Cook Associates Inc.

1040 Avenue of the Americas, 24th FL, New York, NY 10018

(914) 250-0700

STATEMENT OF CLAIM FOR HEARING AID BENEFIT

MEMBER MUST COMPLETE THIS SECTION

Patient's Name:	Relationship To Member: ☐ self ☐ spouse ☐ child ☐ other	Patient's Birthday:
Name of Member:	Social Security Number:	Date of Birth:
Home Address City State Zip Code		Phone Number:
Name of School or Building Assignment:	Date of Employment in Yonkers' System:	

Are Hearing Aid Benefits available from any other provider for this patient? ☐ YES ☐ NO

If yes, indicate the following and annex the original Explanation of Benefits from primary carrier, if applicable.

Spouse's Name: _____ Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Date of Birth: _____

Spouse's Benefit Plan(S) No. and Insurer(S): _____

Note: The Fund pays up to a maximum of $600 toward the cost of hearing aids once every 2 consecutive years for each eligible person. Refer to the Benefit Booklet published by the Fund for a complete benefit description.

This form, when completed, is to be mailed with an original itemized receipt marked "Paid" describing the appliance purchased, the date purchased, amount charged and the name of the patient to: Yonkers Federation of Teachers Welfare Fund c/o Daniel H. Cook Associates, 1040 Avenue of the Americas, 24th FL, NY, NY 10018, Within 90 days of the date you received the services listed below.

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN, OTOLOGIST OR AUDIOLOGIST

Patient's Name_____ Service Rendered and Charges: $_____

Date of most recent hearing test_____ Hearing Test and Analysis $_____

Date last Hearing Aid prescribed for patient _____ Hearing-Aid Fitting $_____

Hearing Loss Percentage (%) Left Ear____ Right Ear ____ Hearing-Aid Appliance $_____

Type or model_____

Total $_____

Signature _____

Office Address _____

Telephone Number _____

I certify that the foregoing information is true and correct. I understand I am financially responsible for any expenses incurred not covered by this benefit.

Date_____ Members Signature _____

FOR ADMINISTRATOR ONLY

MEMBER/DEPENDENT	**AMOUNT PAID $_____**	**FOR YEAR _____**