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 PRESCRIPTION APPLIANCE BENEFIT

MEMBER MUST COMPLETE THIS SECTION

Patient's Name:	Relationship To Member:	Patient's Birthdate:
Name of Member:	Member ID #	Date of Birth:
Home Address City State Zip Code		Home Phone:
Name of School or Building Assignment:	Date of Employment in Yonkers School System:	

ARE PRESCRIPTION APPLIANCE BENEFITS AVAILABLE FROM ANY OTHER PROVIDER FOR THIS PATIENT? YES: NO:

If YES, Indicate the following and annex the original Explanation of Benefits from the primary carrier, If applicable.

SPOUSE'S NAME: _____ SPOUSE'S SOCIAL SECURITY NUMBER: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSES'S BENEFIT PLAN(S) NO. AND INSURER(S): _____

Check one of the following: I am enclosing a voucher from

____ My State Sponsored Health Plan

Amount Claimed $ _____ ____ My HMO

____ Other

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 _____

This form, when completed, is to be mailed WITH THE VOUCHER AND A COPY OF THE RECEIPT MARKED "PAID" STATING A COMPLETE DESCRIPTION OF THE APPLIANCE DATE PURCHASED, NAME OF PERSON APPLIANCE WAS PURCHASED FOR AND AMOUNT PAID to: YONKERS FEDERATION OF TEACHERS WELFARE FUND, C/O DANIEL H. COOK ASSOCIATES, 1040 AVENUE OF THE AMERICAS, 24TH FL, NEW YORK, NY, 10018 within 90 days of the receipt of your voucher from the State sponsored health plan.

Note: Prescription appliances include crutches, wheelchairs, artificial limbs, orthopedic appliances and other necessary medical equipment required for therapeutic use.

The voucher you submitted with this application shows the amount of payment made to you or your dependent for the prescribed appliance. The Prescription Appliance Benefit provided by the Fund will reimburse you for the full deductible amount and the cost of the prescription appliance not covered by the State plan. Refer to the Benefit Booklet for a complete description of this benefit.

FOR ADMINISTRATOR ONLY

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