LAKELAND CIVIL SERVICE WELFARE FUND

FLEXIBLE BENEFIT PROGRAM CLAIM FORM

Dental and Vision Only ******** please see specifics listed below**

MEMBER'S NAME: _____

MEMBER'S ADDRESS: _____

SOCIAL SECURITY #: _____

Maximum Benefit: $300.00

Services must be incurred between July 1, 2024, and June 30,2025. All claims must be received at Daniel H Cook Associates by September 30, 2025.

Name of Member Or Dependent	**Service Category #**	**Date of Service**	**Amount not covered any other plan**
_____	_____	_____	**$**_____
_____	_____	_____	**$**_____
_____	_____	_____	**$**_____
_____	_____	_____	**$**_____
_____	_____	_____	**$**_____

**********Service Category**********

1. **Dental expenses incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other dental plan.**
2. **Vision expenses incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other vision plan.**
3. **Please submit the copies of explanation of payment from your dentist or vision provider.**

_____ _____

Signature **Date**

Please email completed form to intake@dhcook.com or return to:

LAKELAND CIVIL SERVICE WELFARE FUND

c/o Daniel H Cook Associates

1040 Avenue of the Americas, 24th FL,

New York, NY 10018

(914) 250-0700