

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, 2026, and June 30, 2027. All claims must be received at Daniel H Cook Associates by September 30, 2027.

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 complete all sections of this form and return to:

LAKELAND CIVIL SERVICE WELFARE FUND

c/o Daniel H Cook Associates

1040 Avenue of the Americas, 24th FL,

New York, NY 10018