SOMERS FACULTY ASSOCIATION BENEFIT TRUST FUND

TRUST ADDITIONAL BENEFIT PROGRAM FOR DENTAL AND VISION CLAIM FORM

MEMBER'S NAME: _____

Member Address: _____

Number on Member ID Card (ID# or SSN): _____ **Group #:**

Maximum Benefit: $300 Family

- Services must be incurred between **July 1, 2026** and **June 30, 2027**
- All claims for the fiscal year ending on June 30, 2027, must be received by Daniel H. Cook by September 30, 2027

Name of Member or Dependent	Service Category (Dental or Vision)	Date of Service	Amount not covered by any other plan

- Dental & Vision expenses must be incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other dental or vision plan.
- Dental and Vision claim must be submitted to the plan prior to request for reimbursement under this benefit
- Only eligible dental or vision **out of pocket expenses** are reimbursed
- If you have any questions regarding your claims submission, please call (212) 505-5050.

Please complete all sections of this form, attach the copies of the bills, explanation of benefits **and circle the amount not covered by any other dental or vision plan.**

Signature: Date:

Claims can be submitted in one of three ways:

Claim forms can be mailed to this address:	**Members can email claims to:**
SOMERS FACULTY ASSOC. TRUST FUND **C/O Daniel H. Cook Associates, Inc.** **1040 Avenue of the Americas, 24th Floor** **New York, NY 10018** **(212) 505-5050**	**intake@dhcook.com** **Please note: All claim forms and attachments must be submitted in PDF format.**