

BETHPAGE CONGRESS OF TEACHERS BENEFIT TRUST FUND

MAIL TO:

Administrative Services Only, Inc.
PO Box 9005, Dept. 118-M
Lynbrook, NY 11563-9005
516-396-5500
www.asonet.com

2009 MEDICAL, DENTAL, PRESCRIPTION & OPTICAL OUT-OF-POCKET REIMBURSEMENT CLAIM FORM

Maximum Benefit \$200 per member and/or dependents
for calendar year 2009 (January 1- December 31)

- Benefit Information
- Claim Forms
- Claim Inquiries

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO. 		DAYTIME TELEPHONE NUMBER: EVENING TELEPHONE NUMBER:		
PATIENT NAME	BIRTH DATE	SPOUSE <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/>		

HOW TO FILE A CLAIM

1. This plan is designed to reimburse the following out-of-pocket expenses:
 - a. Medical co-pays, deductibles & non-covered medical expenses.
 - b. Dental co-pays, deductibles & non-covered dental expenses.
 - c. Prescription co-pays and non-covered prescription expenses.
 - d. Optical co-pays and non-covered optical expenses.

These are the only benefits you and your covered dependents are entitled to under this plan. All other charges are plan exclusions and are not covered by this plan.

YOU MUST SUBMIT EXPENSES TO THIS PLAN BEFORE FILING FOR REIMBURSEMENT UNDER ANY SECTION 125 FLEXIBLE SPENDING ACCOUNT.

2. Please sign and complete this claim form.
3. Attach copies of Explanation of benefit forms or pharmacy printouts that clearly demonstrate proof of out-of-pocket expenses for the coverages indicated above. **YOU MUST SUBMIT YOUR EXPENSES EITHER AFTER YOU HAVE ACCUMULATED \$200 IN OUT OF POCKET EXPENSES OR AT THE END OF THE CALENDAR YEAR (December 31st)**
4. All claims for benefits must be postmarked no later than March 31st of the following year.

FAILURE TO FILE THE REQUIRED DOCUMENTATION WILL CAUSE DELAYS IN PROCESSING YOUR CLAIM.

IMPORTANT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS, WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY Benefits will not be assigned to ANY provider of service.

SIGNATURE OF MEMBER

DATE

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2010 MEDICAL, DENTAL, PRESCRIPTION & OPTICAL OUT-OF-POCKET REIMBURSEMENT CLAIM FORM

**Maximum Benefit \$250 per member and/or dependents
for calendar year 2010 (January 1- December 31)**

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO. 	DAYTIME TELEPHONE NUMBER:		EVENING TELEPHONE NUMBER:	
PATIENT NAME	BIRTH DATE	SPOUSE <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/>		

HOW TO FILE A CLAIM

1. This plan is designed to reimburse the following out-of-pocket expenses:

- Medical co-pays, deductibles & non-covered medical expenses.
- Dental co-pays, deductibles & non-covered dental expenses.
- Prescription co-pays and non-covered prescription expenses.
- Optical co-pays and non-covered optical expenses.

These are the only benefits you and your covered dependents are entitled to under this plan. All other charges are plan exclusions and are not covered by this plan.

YOU MUST SUBMIT EXPENSES TO THIS PLAN BEFORE FILING FOR REIMBURSEMENT UNDER ANY SECTION 125 FLEXIBLE SPENDING ACCOUNT.

- Please sign and complete this claim form.
- Attach copies of Explanation of benefit forms or pharmacy printouts that clearly demonstrate proof of out-of-pocket expenses for the coverages indicated above. **YOU MUST SUBMIT YOUR EXPENSES EITHER AFTER YOU HAVE ACCUMULATED \$250 IN OUT OF POCKET EXPENSES OR AT THE END OF THE CALENDAR YEAR (December 31st)**
- All claims for benefits must be postmarked no later than March 31st of the following year.

FAILURE TO FILE THE REQUIRED DOCUMENTATION WILL CAUSE DELAYS IN PROCESSING YOUR CLAIM.

IMPORTANT NOTICE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS, WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

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SIGNATURE OF MEMBER

DATE