

YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

2729 Crompond Road
Yorktown Heights, NY 10598
914-962-7442

HEARING AID BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20_____

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A reimbursement of up to \$900,⁰⁰ is paid for actual expenses incurred by a member for purchase of a hearing aid. You must submit copies of paid bills with this claim form. Please be aware that payment on a claim for a hearing aid is not made until after the trial period for the hearing aid has expired, usually 30 to 60 days from time of purchase.

NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE YEAR IN WHICH SUCH HEARING AID EXPENSES WERE INCURRED.

MEMBER MUST COMPLETE THIS SECTION

NAME OF MEMBER _____

BUILDING ASSIGNMENT _____

JOB CATEGORY _____

AMOUNT CLAIMED _____

I understand that I am responsible for any expense not covered by this benefit.

Date: _____ Member's Signature: _____

Retirees, please provide current address that you want benefit mailed to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

FOR TRUSTEE'S USE ONLY

DATE OF PAYMENT _____

CHECK# _____

AMOUNT PAID _____

CLAIMS MAY BE SENT VIA INTERSCHOOL MAIL TO YCT WELFARE FUND IN BUILDING B