

# YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

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



## MEDICAL DEDUCTIBLE BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20\_\_\_\_\_

You may claim up to limit per calendar year for the costs of "MEDICAL DEDUCTIBLE" for yourself or a member of your family, provided they meet the requirements as dependents. If both adults have medical coverages, the same information must be submitted to the Fund from both medical carriers. You must submit a copy of the appropriate bill indicating the patients name, date(s) of service, type of service and the charges, and an indication of the amount of deductible incurred in those charges. Payment will be made directly to you.

**CLAIMS UNDER THIS BENEFIT CATEGORY MAY BE SUBMITTED  
ONLY ONCE A YEAR FOR REIMBURSEMENT**

**NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE  
YEAR IN WHICH SUCH MEDICAL 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 TRUSTEES USE ONLY**

DATE OF PAYMENT \_\_\_\_\_

CHECK# \_\_\_\_\_

AMOUNT PAID \_\_\_\_\_

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