

YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

2729 Crompond Road
Yorktown Heights, NY 10598
voice: 914-962-7442 • fax: 914-302-7715

OFFICE VISIT CO-PAY BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20_____

To receive your office visit co-pay benefit reimbursement incurred by you as a member or eligible dependent, you must submit a copy of your EOB from your insurance company showing your co-pays OR submit receipts from the doctor's office, that have the doctor's name and/or group printed on it, as well as the name of the patient, date of service and amount of co-pay paid. Generic receipts will not be accepted.

You may submit a claim for this benefit only once per year. Payment will be made only in compliance with Fund rules.

NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE YEAR IN WHICH SUCH OFFICE VISIT 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