COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

HEARING AID BENEFIT CLAIM FORM

To receive your Hearing Aid Benefit you must:

1. Complete this form.
2. Attach an itemized bill or receipt from the provider of service for all eligible expenses containing the following information. Cancelled checks are not acceptable.
   - Name of person and date hearing aid was received
   - Amount paid
   - Name of provider rendering service
   - Number of hearing aids received
3. Mail or email completed form and attachment to:

COBANC Health & Welfare Fund
1 Old Country Rd.
Ste 282
Carle Place, NY 11514-1845

Email: info@cobanc.org

MEMBER INFORMATION – PLEASE PRINT

Employment Status:
¯ Active ¯ Part-Time ¯ Retiree

Patient Name: _____ Date of Birth: _____

Member's Name: _____ Date of Birth: _____

Member's Address: _____
Street

_____
City State Zip Code

¯ Check here if there is a new address. You must notify COBANC prior to submitting this claim.

Provider Name: _____

Provider Address: _____
Street

_____
City State Zip Code

I hereby request payment for the above claimed benefit. I certify that either my eligible dependent(s) or I have incurred these expenses and have not been previously reimbursed.

Member's Signature: _____ Date: _____