COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

HOSPITAL INCOME BENEFIT CLAIM FORM

Return this form to:
COBANC Health & Welfare Fund
1 Old Country Rd., Ste 282
Carle Place, NY 11514-1845
Email: info@cobanc.org

INSTRUCTIONS FOR SUBMITTING CLAIM

1. Complete Part A. Answer all questions fully; incomplete answers may delay payment of benefit.
2. Have Part B completed by the hospital or by the attending physician at time of discharge.

PART A – MEMBER'S STATEMENT – PLEASE PRINT

Patient Name	Relationship to Member	Sex	Patient Date of Birth	Full-time Student
	☐ Self ☐ Spouse ☐ Child			☐ Yes ☐ No

Member Name: First	Middle	Last	Member Date of Birth

Member Mailing Address	City	State	Zip

Is disability due to any occupational cause?

Did confinement occur while this person was on active duty in any military, naval or air force of any country? ☐ Yes ☐ No

Name of Hospital where confined	City	State

Name of Attending Physician	Address	Date of first treatment

Nature of sickness, injury
(if injury, give date of accident)

To all physicians, hospitals, clinics, dispensaries, sanitariums, druggists, and all other agencies (including other insurance companies): You are authorized to permit Court Officers Benevolent Association of Nassau County Health and Welfare Fund or its representative to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions and medical expenses of:

_____
(Print Name of Patient)

Such information may be used to the extent deemed necessary by the FUND to determine the validity or amount payable on account of this claim.

Date _____ X _____
Member's Signature (insured)

PART B – CERTIFICATION OF CONFINEMENT

Check one: Completed by ☐ Hospital ☐ Attending Physician

Name of Patient	Age	Date Admitted	Still Confined?	Date Discharged
			☐ Yes ☐ No	

Diagnosis from records

Dates of any previous confinement	Is condition due to any occupational cause?
From: _____ To: _____	☐ Yes ☐ No

Completed by Taken from records on _____

Name _____ Title _____

Address _____ Signature X _____

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HOSPITAL INCOME BENEFIT
ACTIVE MEMBER AND COVERED DEPENDENTS ONLY

The Plan will pay up to the amount indicated in the Schedule of Benefits for up to thirty-one (31) days for a hospital confinement ordered by a doctor as a result of an accident or sickness, excluding pregnancy.

The day on which you are discharged from the hospital will not be considered as a day of confinement.

Separate hospital confinements due to the same cause will be considered one confinement, if separated by less than two (2) weeks of full-time work with respect to you, or with respect to your dependents, if separated by less than two (2) weeks of your spouse's or child's return to normal activities.

EXTENDED BENEFITS

If your benefits terminate, benefits will nevertheless be paid for a confinement commencing within thirty-one (31) days, provided it results from a total disability that began while the benefit was in force and benefits would have been paid had the benefit continued.

EXCLUSIONS

Should you not be working on the day you would ordinarily become covered for the benefit, the benefit will be delayed until you return to full-time work.

Confinements due to an act of war, or while on full-time active military duty are not covered.

Hospital benefits will NOT be payable with any maternity benefit including C-section. Hospital benefits will only be paid if a medical condition developed because of the pregnancy/delivery.

Routine nursery care of a newborn is not covered under the benefit.

Please refer to the Summary Plan Description for the current benefit amount

RETURN COMPLETED FORM TO:

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