COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

MATERNITY / ADOPTION BENEFIT CLAIM FORM

To receive your Maternity/Adoption Benefit you must:

1. Complete this form.
2. Attach a copy of the new child's birth certificate(s) or adoption documentation.
3. Attach a new fully completed Health & Welfare Enrollment/Update Form.
4. Mail or email completed form and attachments to:

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

Email: info@cobanc.org

MEMBER INFORMATION – PLEASE PRINT

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.

CHILD INFORMATION

1st Child's Name: _____ Date of Birth: _____

2nd Child's Name: _____ Date of Birth: _____

3rd Child's Name: _____ Date of Birth: _____

I hereby request payment for the above claimed benefit. I certify that the above statements and any supporting documents are true and correct.

Member's Signature: _____ Date: _____