COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

SUPPLEMENTAL PRESCRIPTION/MEDICAL REIMBURSEMENT CLAIM FORM

It is your responsibility to ensure your claim form is received by COBANC on or before April 15th. It is suggested that you maintain a copy of your completed claim form and/or enclosures.

To receive this benefit, you must be a member of COBANC at the time of service, submission, review of the claim, and disbursement of funds.

- Complete this form. All claims must be submitted by April 15th for payment of the prior calendar year's claims.
- 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, date of birth, and relationship to the member.
  - Dates when the expenses were incurred (e.g., prescriptions, medical visits, health insurance costs, etc.).
  - Name of provider rendering service.
  - Amount incurred by patient for that event.
- Members and/or their spouses may submit paystubs or receipts that show the total amount paid for their health insurance.
- 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 Court Building/Command: _____

Member's Name: _____ Date of Birth: _____ Cell Phone: _____

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.

PRESCRIPTION/MEDICAL CLAIM INFORMATION

Name	Date of Birth	Relationship to Member	Dates When Expenses Incurred	Provider's Name	Amount Claimed

Total: $_____

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. I understand that this must be returned to COBANC by April 15th to receive payment.

Member's Signature: _____ Date: _____

PLEASE ALLOW UP TO 45 DAYS FOR PROCESSING