RETURN TO:
SCCEA, Welfare Fund
1363-24 Veterans Memorial Hwy.
Hauppauge, New York 11788
(631) 231-3983 FAX: 631-231-3986
email: sccea@aol.com

Suffolk County Court Employees Association Welfare Fund

HEALTH INSURANCE PREMIUM and PRESCRIPTION / CO-PAY REIMBURSEMENT BENEFIT FORM - **2026**

MEMBER INFORMATION:

Member Name		Birthdate		Social Security # LAST 4 DIGITS XXX – XXX - ____ ____ ____ ____
Street Address	City	State	Zip	Plan Status ☐ Single ☐ Family
Phone (Day Time)				

****POSITION/JOB TITLE:**_____

****LOCATION/WORK STATION:**_____

☐ **FULL TIME EMPLOYEE $300** ☐ **PART TIME EMPLOYEE $100** ☐ **RETIRED EMPLOYEE $250**

HEALTH INSURANCE PREMIUM and PRESCRIPTION / CO-PAYMENT REIMBURSEMENT – PLEASE ATTACH DOCUMENTS FOR CLAIM.

- **The copy of pay stub OR retirement statement showing the payment of the Health Insurance Premium. (e.g., Regular Before Tax Health or Health Ins. Premium)**

OR

- **ONE CONSOLIDATED PRINT OUT** of the copayments from the Medical Plan **and/or** Pharmacy/Prescription Plan showing all individual co-payments or prescription charges **and/or** heart, lung and body scan receipts.

This benefit must be coordinated with any other plan under which similar benefits provided so that the total benefits available will not exceed 100% if the actual charges paid.

EXCLUSIONS AND LIMITATIONS:

1. This benefit does not apply to costs covered by your regular health Insurance plan except applicable co-payment expenses.
2. Dental co-payments are not eligible. Deductible and/or co-insurance payments are not eligible.
3. This does not cover expenses in excess of the calendar year maximum.
4. **Credit card receipts and cash register receipts are not acceptable for prescription drug reimbursement**.

GENERAL INSTRUCTIONS

1. Claim forms should only be submitted **ONCE** for benefit reimbursement, either when the maximum allowable benefit has been met or, if less than, on or before the last business day of the year.
2. You may submit claims for the above-mentioned benefits up to the allowable maximum.
3. If a husband and wife are both full-time employees, the claims must be submitted together.

ALL REIMBURSEMENT CLAIMS FOR HEALTH INSURANCE PREMIUM and/or PRESCRIPTION/CO-PAYMENTS FOR THE CALENDAR YEAR OF **2026** MUST BE **RECEIVED BY THE UNION OFFICE** NO LATER THAN **DECEMBER 31st, 2026 (THE LAST BUSINESS DAY OF 2026) **NO EXCEPTIONS****

AUTHORIZATION TO RELEASE INFORMATION: **Authorization must be signed or payment will not be made.**

I hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Suffolk County Court Employees Association, Welfare Fund or its designated agent to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that the information submitted by me in support of this claim is true and correct.

Reimbursement Amount Requested $ _____

Members Signature: _____ Date: _____

Rev. 12/25

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