NYS COURT OFFICERS SECURITY BENEFIT FUND
DAY CARE, PRESCRIPTION DRUG CO-PAY, HEALTH INSURANCE CO-PAY AND VISION CO-PAY

PRINT OR TYPE ALL INFORMATION

April 1, 2025 to March 31, 2026

First Name	Initial	Last Name	
Address		City	
State	Zip Code	Email	Shield #
Home Telephone	Work Telephone	Cell Phone	
Court Assignment	Work Address		
Hire Date in Current Title			

I CERTIFY THAT I HAVE ATTACHED RECEIPTS TOTALING $700.00 OR LESS FOR APPROVED DAY CARE, PRESCRIPTION DRUG CO-PAYMENTS, HEALTH INSURANCE CO-PAYMENTS AND VISION CO-PAYMENTS.

I ALSO CERTIFY THAT IF I RECEIVED $675.00 FOR 2024/2025 THE MONEY WAS UTILIZED FOR APPROVED DAY CARE, PRESCRIPTION DRUG CO-PAYMENTS, HEALTH INSURANCE CO-PAYMENTS AND VISION CO-PAYMENTS

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DATE SIGNATURE

ONLY FULL TIME MEMBERS HIRED PRIOR TO JANUARY 1, 2025, AND WORKING IN A TITLE COVERED BY THE NEW YORK STATE COURT OFFICERS ASSOCIATION ARE ELIGIBLE FOR THIS BENEFIT. ANYONE ON ANY LEAVE OR NO PAY STATUS DURING THIS PERIOD (1/1/25 TO 3/31/26) IS NOT ELIGIBLE FOR THIS BENEFIT.

THE MAXIMUM AMOUNT THIS BENEFIT ALLOWS IS $700.00

ONCE YOU REACH $700.00 IN EXPENSES, COMPLETE ALL FORMS AND ATTACH ALL HEALTH INSURANCE EOB'S AND, PRESCRIPTION, DAY CARE AND VISION RECEIPTS, AND SUBMIT TO THE BY APRIL 30, 2026.

IF YOU DO NOT REACH $700.00 IN EXPENSES BY MARCH 31, 2026, COMPLETE THIS FORM AND ATTACH ALL HEALTH INSURANCE EOB'S AND PRESCRIPTION, DAY CARE AND VISION RECEIPTS AND SUBMIT TO THE SECURITY BENEFIT FUND BY APRIL 30, 2026, AND YOU WILL RECEIVE PAYMENT BASED ON EXPENSES SUBMITTED.

ONLY ONE SUBMISSION FOR PAYMENT PERMITTED
* NO EMAILS AND OR FAXES ACCEPTED*
MAIL APPLICATION AND ATTACHMENTS TO
NYS COURT OFFICERS SECURITY BENEFIT FUND
321 BROADWAY, SUITE 600
NEW YORK, NEW YORK 10007

NEW YORK STATE COURT OFFICERS SECURITY BENEFIT FUND

April 1, 2025 to March 31, 2026

Day Care Benefit, Prescription Drug Co-Pay Benefit

Health Insurance Co-Pay Benefit and Vision Co-Pay Benefit

All documents must be for services received between April 1, 2025 and March 31, 2026.

DAY CARE BENEFIT

Ages 6 and under. Attach photocopy of Day Care License, copy of paid bills and photocopy of cancelled check/credit card payment. (Cash payments NOT acceptable)

PRESCRIPTION DRUG CO-PAY BENEFIT

Complete the prescription co-pay benefit claim form and attach a printout from your pharmacy showing name of pharmacy, name of patient, name of drug, date of prescription, original cost, and co-pay for each prescription. ONLY PRESCRIPTION CO-PAYS ARE ELIGIBLE FOR REIMBURSEMENT. DO NOT SUBMIT INDIVIDUAL RECEIPTS . ONLY PHARMACY PRINTOUT ACCEPTABLE.

HEALTH INSURANCE CO-PAY AND VISION CO-PAY BENEFIT

Complete the insurance co-pay benefit claim form and attach EOB (Explanation of Benefits) for each medical/hospital co-pay showing name of patient, date of service and co-pay. Spouse and/or Child EOB acceptable. For vision attach copy of vision bill and proof of payment (Cash payments NOT acceptable). Lasik Surgery is not eligible.

THE MAXIMUM BENEFIT ALLOWANCE IS $700.00

Once you reach $700.00 in expenses complete all forms and submit all required documentation to the Security Benefit Fund by April 30, 2026.

If by APRIL 30, 2026, you do not reach $700.00 in expenses complete all forms and submit all required documentation to the Security Benefit Fund.

ONLY ONE SUBMISSION FOR PAYMENT PERMITTED.

CLAIMS SUBMITTED AFTER APRIL 30, 2026, WILL BE DENIED

*** NO EMAILS AND OR FAXES ACCEPTED***

MAIL APPLICATION AND ATTACHMENTS TO

NEW YORK STATE COURT OFFICERS SECURITY BENEFIT FUND

321 BROADWAY, SUITE 600

NEW YORK, NEW YORK 10007

Prescription Drug Co-pay Benefit Claim Form

Attach photocopy of each receipt. Do not send original receipts. **Page _____ of _____**

Prescription Date	Patient	Drug	Pharmacy	Original Cost	Co-pay Paid

DO NOT EMAIL FORM

Totals		

Print Name: _____ **Signature:** _____ **Date:** _____

Health Insurance and Vision Co-pay Benefit Claim Form

Attach photocopy of each co-pay for Health Insurance, for Vision Attach Bill and Proof of Payment. DO NOT EMAIL FORMS.

Date	Patient	Hospital/Doctor/ Vision store	Original Cost	Co-pay Paid
			Total	

Print Name: _____ Signature: _____ Date: _____