

**NYS SECURITY BENEFIT FUND
DAY CARE, PRESCRIPTION DRUG COPAY,
HEALTH INSURANCE COPAY AND VISION COPAY**

PRINT OR TYPE ALL INFORMATION

April 1, 2026 to March 31, 2027

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 \$800.00 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 \$700.00 FOR 2025/2026 THE MONEY WAS UTILIZED FOR APPROVED DAY CARE, PRESCRIPTION DRUG COPAYMENTS, HEALTH INSURANCE AND VISION COPAYMENTS

DATE

SIGNATURE

ONLY FULL TIME MEMBERS HIRED PRIOR TO JANUARY 1, 2026 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 (1/1/26 TO 3/31/27 IS NOT ELIGIBLE FOR THIS BENEFIT

THE MAXIMUM AMOUNT THIS BENEFIT ALLOWS IS \$800.00

ONCE YOU REACH \$800.00 IN EXPENSES, COMPLETE ALL FORMS AND ATTACH ALL HEALTH INSURANCE EOB'S, PRESCRIPTION, DAY CARE AND VISION RECEIPTS, AND SUBMIT TO THE UNION OFFICE.

IF YOU DO NOT REACH \$800.00 IN EXPENSES BY MARCH 31, 2027, COMPLETE THIS FORM AND ATTACH ALL HEALTH INSURANCE EOB'S AND PRESCRIPTION PRINT OUT, DAY CARE AND VISION RECEIPTS AND SUBMIT TO THE SECURITY BENEFIT FUND BY APRIL 30, 2027. YOU WILL RECEIVE A PAYMENT BASED ON EXPENSES YOU INCURRED.

ONLY ONE SUBMISSION FOR PAYMENT PERMITTED

NO EMAILS AND/OR FAXES ACCEPTED

**MAIL APPLICATIONS AND ATTACHMENTS TO
NYS COURT OFFICERS SECURITY BENEFIT FUND**

**321 BROADWAY, SUITE 600
NEW YORK, NY 10007**

NEW YORK STATE COURT OFFICERS ASSOCIATION

April 1, 2026 to March 31, 2027

Day Care Benefit, Prescription Drug Co-pay Benefit

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

All documents must be for services between April 1, 2026 and March 31, 2027.

DAY CARE BENEFIT

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

PRESCRIPTION DRUG CO-PAY BENEFIT

Provide a printout form 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.

PHARMACY PRINTOUT MUST BE SUBMITTED.

IF YOU SUBMIT INDIVIDUAL RECEIPTS YOUR CLAIM WILL BE REJECTED.

HEALTH INSURANCE AND VISION COPAY 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 the paid vision bill from the Vision Store you used, copy of vision prescription from a Licensed OPTOMETRIST OR Licensed OPHTHALMOLOGIST and proof of payment (CANCELLED CHECK AND OR CREDIT CARD RECEIPT). Cash payments NOT acceptable. LASIK Surgery is not covered. Non-Prescription sunglasses are not covered.

THE MAXIMUM BENEFIT ALLOWANCE IS \$800.00

Once you reach \$800.00 in expenses complete all forms and submit all required documentation to the Security Benefit Fund by April 30, 2027.

If by March 31, 2027, you do not reach \$800.00 in expenses, complete the forms and submit with all required documentation to the Security Benefit Fund.

ONLY ONE SUBMISSION FOR PAYMENT PERMITTED.

CLAIMS SUBMITTED AFTER APRIL 30, 2027, WILL BE DENIED.

NO EMAILS AND/OR FAXES ACCEPTED

Health Insurance and Vision Co-pay Benefit Claim Form

Attach photocopy of each co-pay for Health Insurance,

for Vision Attach Bill, Prescription from Licensed Doctor, Copy of Paid Bill and Proof of Payment. Non-prescription sunglasses NOT covered.

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

UnitedHealthcare Service LLC
THE EMPIRE PLAN
P.O. BOX 1600
KINGSTON, NY 12402-1600

Explanation of Benefits

Enrollee/Patient: [REDACTED]
Enrollee ID: [REDACTED]
Relationship: EE
Group name: STATE OF NEW YORK
Group number: 0030500
Plan/Product: NY Self Funded PPO

DPSS\$SPKG
[REDACTED]
[REDACTED]
[REDACTED]

SAMPLE

Hi, [REDACTED]

THIS IS NOT A BILL. This Explanation of Benefits (EOB) is a summary of services received and how plan benefits were applied.

To the right is the total amount you may owe for the services included in this statement – but, depending on when you receive this statement, that amount may not reflect payments you've already made. Visit myuhc.com to see the most up to date amounts.

Use this EOB as a reference or retain as needed.

Services in this statement occurred
between Jan 8, 2026 - Jan 9, 2026

Provider billed \$9,493.00

Your total amount owed \$25.00

Scan this code to download
the **UnitedHealthcare** app
and see your most up-to-date
information.



The amount next to Your total amount owed is
what counts towards the \$800



Plan balances

As of 01/26/2026 for plan year 2026

Balances for [REDACTED]		Maximum amount	Progress so far	Remaining amount
Network	Out-of-pocket limit	\$2,750.00	\$ 100.00	\$2,650.00
Out-of-Network	Deductible	\$1,250.00	\$0.00	\$1,250.00
	Out-of-pocket limit	\$3,750.00	\$25.00	\$3,725.00
Physical Medicine	Deductible	\$250.00	\$0.00	\$250.00

Got questions?

Get in touch with customer service at **877-769-7447**



UnitedHealthcare Service LLC
THE EMPIRE PLAN
P.O. BOX 1600
KINGSTON, NY 12402-1600

Explanation of Benefits

Enrollee/Patient: [REDACTED]
Enrollee ID: [REDACTED]
Relationship: EE
Group name: STATE OF NEW YORK
Group number: 0030500
Plan/Product: NY Self Funded PPO

DPSS\$PKG

[REDACTED]

[REDACTED]

WASHINGTON CROSSING PA 18877-1077

SAMPLE

Hi, **MARY**.

THIS IS NOT A BILL. This Explanation of Benefits (EOB) is a summary of services received and how plan benefits were applied.

To the right is the total amount you may owe for the services included in this statement – but, depending on when you receive this statement, that amount may not reflect payments you’ve already made. Visit myuhc.com to see the most up to date amounts.

Use this EOB as a reference or retain as needed.

Services in this statement occurred
between Jan 8, 2026 - Jan 9, 2026

Provider billed \$9,493.00

Your total amount owed \$25.00

Scan this code to download
the **UnitedHealthcare® app**
and see your most up-to-date
information.



The amount next to Your total amount owed is
what counts towards the \$800



Plan balances

As of 01/26/2026 for plan year 2026

Balances for **MARY**

		Maximum amount	Progress so far	Remaining amount
Network	Out-of-pocket limit	\$2,750.00	\$100.00	\$2,650.00
Out-of-Network	Deductible	\$1,250.00	\$0.00	\$1,250.00
	Out-of-pocket limit	\$3,750.00	\$25.00	\$3,725.00
Physical Medicine	Deductible	\$250.00	\$0.00	\$250.00

Got questions?

Get in touch with customer service at **877-769-7447**

