

RETURN TO:
 SCCEA, Inc
 1300 Veterans Memorial Highway
 Suite 130
 Hauppauge, NY 11788
 (631) 231-3983

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND HEARING BENEFIT CLAIM FORM

MEMBER/EMPLOYEE INFORMATION

Member Name	Birth date	Social Security#
Street Address		
City	State	Zip
Member's Work Location	Telephone#- Day _____ Evening _____	
ARE ANY OTHER HEARING AID BENEFITS AVAILABLE FOR THIS PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IS THIS CLAIM THE RESULT OF:		
Accident or Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Occupational Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		

THIS SECTION IS TO BE COMPLETED BY THE LICENSED PROVIDER

Date of most recent hearing test	Date of prescription for hearing aid	Hearing loss (%)
Hearing Aid Type or Model		Left ear ____ Right ear ____
Fee for Hearing Aid Appliance \$ _____		
<p>1. The Plan will reimburse eligible Employees up to a maximum of \$525 for one hearing aid appliance, and up to \$75 for repair to a hearing aid appliance once every four years.</p> <p>2. Claims for hearing aid appliances must first be submitted to the eligible employees health plan carrier, before consideration on SCCEA Welfare Fund</p> <p>3. Hearing aid appliances must be prescribed by a duly licensed physician, audiologist or otologist.</p> <p>4. Hearing aid exams, tests or fittings are not covered.</p> <p>5. Mail completed forms WITH AN ORIGINAL OR COPY OF AN ITEMIZED RECEIPT MARKED "PAID" AND AN EXPLANATION OF BENEFITS from your health plan carrier within 12 months of the date you received the services listed.</p>		

<p>ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.</p> <p><i>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 which may have a bearing on the benefits payable under this or any other plan providing benefits on 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.</i></p>	
Member Signature _____	Date _____