RETURN TO:

SCCEA, Welfare Fund
1363-24 Veterans Memorial Hwy.
Hauppauge, New York 11788
(631) 231-3983 FAX: 631-231-3986

Suffolk County Court Employees Association Welfare Fund

HEALTH INSURANCE PREMIUM and PRESCRIPTION / CO-PAY REIMBURSEMENT BENEFIT FORM - 2019

MEMBER INFORMATION:

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

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

- The copy of pay stub(s) showing the payment of the Health Insurance Premium. (e.g., Regular Before Tax Health)

OR

- The explanation of benefits from the Medical Plan and/or Prescription Plan showing all individual co-payments or paid receipts showing the co-payment, or pharmacy receipts or printouts with prescription information 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 $200 maximum allowable benefit has been met or, if less than $200 after January 1st following the year in which the expenses were incurred.
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, MEDICAL CO-PAYMENTS, OR PRESCRIPTION CO-PAYMENTS, MUST BE FILED BY **JANUARY 15th** OF THE FOLLOWING YEAR. - **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 $ _____ Note: Total allowable 2019 reimbursement - $200 per calendar year.

Members Signature: _____ Date: _____

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