Manhasset Education Association
Trust Fund
SUPPLEMENTAL BENEFIT CLAIM FORM

MEMBER PLEASE PRINT

Member's Last Name	First Name	Member's Social Security Number	
Full Mailing Address No. and Street		Apt. No.	Home Telephone No.
City	State	Zip Code	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? **Yes** ☐ No ☐ IS THIS THE FIRST CLAIM Yes ☐ No ☐
Spouse's Last Name	First Name	Spouse's Social Security Number	
Member's Building	Member's Office Telephone No.	Member's Birthdate Mo. _____ Day _____ Year _____	
IS YOUR SPOUSE EMPLOYED Yes ☐ No ☐	If "YES", give name and address of your Spouse's employer		
Are Benefits Available From Any Other Group Insurance Carrier For This Patient? Yes ☐ No ☐	If "YES", give name of carrier, plus name and I.D. No. of subscriber.		
I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other Group Plan except as indicated above.	**Benefits are payable to member only.** **MEMBER SIGN HERE** _____ **DATE** _____		

This benefit provides reimbursement up to a maximum of $400 annually for the member and spouse combined for any combination of the eligible benefits listed below. This benefit reimburses out-of-pocket expenses for the member and/or spouse only. Members may submit claims for this benefit only once per calendar year. *Effective July 1, 2011* you may also include any unpaid Dental or Vision Care benefit for reimbursement. Members must submit this claim form prior to April 30th of the calendar year following the year charges were incurred. For example, covered expenses incurred from 1/1/11 – 12/31/11 may be claimed prior to 4/30/12.

Mark {X} the benefit (s) for which you are applying:

☐***Medical Deductible/Dental, Vision Care and Co-Payment Reimbursement Benefit.***

The Fund will reimburse, up to the benefit maximum, the amount that the member has paid either as the deductible or the co-payment amount for their basic health coverage, Dental or Vision Care (Effective July 1, 2011). A member must submit the explanation of benefits from their medical plan which shows the deductible or co-payment portion that has been paid by the member for the calendar year.

☐***Prescription Drug***

The Fund will reimburse a member for the co-payments per prescription which have been paid within the calendar year up to the yearly maximum. If the prescription is not covered under your primary coverage, it is not covered under this plan.

-ATTACH COPIES OF ORIGINAL RECEIPTS TO THIS CLAIM FORM-

***attach to this claim form copies of the explanation or denial of benefits showing that you have expenses not reimbursed by any primary or secondary insurance plans. Mail completed forms to:**

MEA TRUST FUND
C/O DANIEL H. COOK ASSOCIATES, INC.
253 WEST 35TH STREET – 12TH FLOOR
NEW YORK, NY 10001