Manhasset Education Association
Trust Fund
2019 SUPPLEMENTAL BENEFIT CLAIM FORM

Member's Last Name	First Name	Member's Social Security Number
Full No. and Street Mailing Address	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 Initial	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** __________

The Fund currently provides a Supplemental Medical Benefit Plan, which reimburses members up to a maximum amount of $500.00 per calendar year for any combination of the following expenses incurred by you and/or your covered spouse or domestic partner and or children**: Dental Expenses** – Any out-of-pocket covered dental expenses incurred. **Vision Expenses** – Any out-of-pocket covered vision expenses incurred.

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

☐ ***Dental Care***

The Fund will reimburse, up to the benefit maximum, the amount that the member has paid for Dental Care. A member must submit the explanation of benefits from their medical plan which shows the payment portion that has been paid by the member for the calendar year.

☐ ***Vision Care***

The Fund will reimburse, up to the benefit maximum, the amount that the member has paid for Vision Care. A member must submit the explanation of benefits from their medical plan which shows the payment portion that has been paid by the member for the calendar year.

***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
(212) 505-5050

FAX 646 381-8866