COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

SUPPLEMENTAL PRESCRIPTION/MEDICAL REIMBURSEMENT PROGRAM CLAIM FORM

It is the member's responsibility to ensure your claim form is received by COBANC on or before April 15th. It is suggested that you maintain a copy of your completed application and/or enclosures.

To receive Supplemental Prescription/Medical reimbursement applicants must be a COBANC member at the time of service, submission and review of application and disbursement of funds.

- Complete this form. All claims must be submitted by April 15th for payments of the prior calendar year's claims.
- Attach an itemized bill or receipt from the Provider of Service for all eligible expenses containing the following information. Cancelled checks are not acceptable.
  - Name of person and date of expense
  - Amount of patient copayment
  - Name of provider rendering service
- Members and/or their spouses may submit paystubs or receipts that show the total amount out laid for their health insurance.
- Mail completed form and attachment to:

COBANC Health & Welfare Fund
1 Old Country Rd
Ste 282
Carle Place NY 11514-1845
ATTN: PRESIDENT

MEMBER INFORMATION - PLEASE PRINT

Employment Status ☐ Active ☐ Retiree ☐ Part -Time Court Building/Command _____

Member Name _____

Date of Birth _____ Member Identification # _____

Member Address _____
Street

_____
City State ZipCode

☐ Check here if there is a new address. You must notify COBANC prior to submitting this claim.

PRESCRIPTION/MEDICAL COPAYMENT INFORMATION

Name	Date of Birth	Relationship to Member	Dates Prescriptions/ Medical Visit	Provider's Name	Amount of Claim

Total _____

I hereby request payment for the above claimed expenses. I certify that either my eligible dependent(s) or I have incurred these expenses and have not been previously reimbursed. I understand that this must be returned to COBANC by April 15th to receive payment.

Member's Signature _____ **Date** _____

PLEASE ALLOW UP TO 45 DAYS FOR PROCESSING