RETURN BY MAIL OR FAX TO:
SCCEA
1363-24 Veterans Memorial
Highway Hauppauge, NY 11788
Phone: (631) 231-3983
Fax: (631) 231-3986

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION, INC.
WELFARE FUND
HEARING BENEFIT CLAIM FORM

Patient Name: _____ Relation to Member: _____ Birth Date: _____

Member Name: _____ Birth Date: _____ Soc.Sec.#: _____

Street Address: _____ Tel. No.: _____

_____

ARE ANY OTHER HEARING AID BENEFITS AVAILABLE TO THIS PATIENT? ☐ YES ☐ NO

IS THIS CLAIM THE RESULT OF:

ACCIDENT OR INJURY? ☐ **YES** ☐ **NO** **OCCUPATIONAL INJURY?** ☐ **YES** ☐ **NO**

THIS SECTION IS TO BE COMPLETED BY THE LICENSED PROVIDER

Date of Most Recent Hearing Test	Date of Prescription for Hearing Aid
Hearing Aid Type and/or Model	

Hearing Loss (%)

Left Ear _____ **Right Ear** _____

Fee for Hearing Aid Appliance $ _____

1. The Plan will reimburse eligible Employees up to a maximum of **$525.00** for one hearing aid appliance, and up to **$75.00** for repair to a hearing aid appliance once every four years.
2. Claims for hearing aid appliances must **FIRST** be submitted to the eligible Employee's health plan carrier, before consideration of the SCCEA Welfare Fund.
3. Hearing aid appliances must be prescribed by a duly-licensed physician, audiologist, or otologist.
4. Hearing aid exams, tests, or fittings are NOT covered.
5. Mail or Fax completed form **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.

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.

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 or services. A photocopy or fax 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.

Member Signature: _____ **Date:** _____