YORKTOWN CONGRESS OF TEACHERS WELFARE FUND

2729 Crompond Road
Yorktown Heights, NY 10598
voice: 914-962-7442 • fax: 914-302-7715

ORTHOTICS BENEFIT

STATEMENT OF CLAIM FOR THE YEAR 20_____

To receive your doctor prescribed orthotics benefit reimbursement for new or re-lined orthotics, incurred by you as a member or eligible dependent, you must submit a copy of your EOB from your insurance company showing they rejected the expense/claim for the orthotics.

A benefit allowance of up to $200.00 will be provided only once in any 5 year period.

Payment will be made only in compliance with Fund rules.

NO PAYMENTS WILL BE MADE FOR ANY REASON 90 DAYS AFTER THE YEAR IN WHICH SUCH ORTHOTICS EXPENSES WERE INCURRED.

MEMBER MUST COMPLETE THIS SECTION

NAME OF MEMBER

* *

BUILDING ASSIGNMENT | JOB CATEGORY | AMOUNT SUBMITTED

I understand that I am responsible for any expense not covered by this benefit.

Date: _____ Member's Signature: _____

***Retirees**, please provide current address that you want benefit mailed to:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

FOR TRUSTEE'S USE ONLY

DATE OF PAYMENT | CHECK# | AMOUNT PAID

CLAIMS MAY BE SENT VIA INTERSCHOOL MAIL TO YCT WELFARE FUND IN BUILDING A