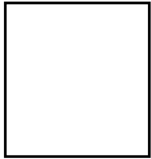
RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
Department 66-S
PO Box 9005
Lynbrook, NY 11563

(516) 396-5500

2017

ASSISTANT DEPUTY WARDENS
DEPUTY WARDENS ASSOCIATION
SECURITY BENEFITS FUND

Health & Wellness Benefit Claim Form
ACTIVE MEMBERS ONLY



MEMBER'S INFORMATION

Member's Name:			Birth Date:	Social Security #: (Last 4 digits) X X X - X X - ________
Street Address:	City:	State:	Zip Code:	Home Phone #:
Email: (Non-DOC)				Cell Phone #:
Member's Work Location: (facility)				Work Phone #:

WHAT IS COVERED ?

This benefit will reimburse you (the Active Member) for covered expenses for the **November 1st, 2016 through October 31st, 2017 plan year** (for any combination of the eligible benefits listed below).

Eligible benefits include:

- **OPTICAL/DENTAL EXPENSES - Active Member and/or your covered Family Members Only** (over and above that which is already covered by the Fund) - up to $700 per plan year;
- **WEIGHT LOSS PROGRAMS - Active Member Only** (this benefit does not include reimbursement for prescription medications or devices utilized for weight loss) (you must also submit evidence of attendance of the program) - up to $700 per plan year;
- **FITNESS PROGRAMS - Active Member Only** (can be individual classes or gym membership; evidence of attendance is required) - up to $700 per plan year;
- **LIFE INSURANCE PREMIUMS - Active Member Only** - up to $700 per plan year; and/or,
- **CANCER, SICKNESS OR ACCIDENT INSURANCE PREMIUMS (Non-Auto) - Active Member Only** - up to $700 per plan year.

You will receive reimbursement for up to $700 of out of pocket expenses that you incur for one or any combination of the items listed above.

THE MAXIMUM REIMBURSEMENT OF UP TO $700 PER ACTIVE MEMBER

HOW DO I FILE FOR BENEFITS ?

Œ Submit your completed and signed claim form for qualified expenses incurred by you, the Active Member, during the **November 1, 2016 through October 31, 2017** benefit period, no later than December 31, 2017.

• Evidence of the expense is required, (i.e., receipts and/or a copy of your pay stub indicating that you have purchased Cancer, Sickness or Accident Insurance). All receipts must reflect expenditures during the **November 1, 2016 through October 31, 2017 benefit period, only, in order to be considered for reimbursement.**

Ž **MAIL FORM AND DOCUMENTATION TO:** Administrative Services Only, Inc, PO Box 9005, Lynbrook, NY 11563.

ONLY ONE $700 CLAIM PER YEAR WILL BE CONSIDERED FOR REIMBURSEMENT

I CLAIM REIMBURSEMENT FOR THE BELOW LISTED COVERED BENEFIT(S)

I have included evidence of the actual expense(s), (i.e., receipts and/or a copy of your pay stub) indicating the expenses incurred by me. All receipts must reflect expenditures made during the **November 1, 2016 through October 31, 2017** benefit period, to be considered for reimbursement.

CHECK BOX	COVERED BENEFIT	EXPENSE INCURRED
	OPTICAL/DENTAL EXPENSES - Active Member and/or your covered Family Members Only (over and above that which is already covered by the Fund) - up to $700 per year;	
	WEIGHT LOSS PROGRAMS - Active Member Only (this benefit does not include reimbursement for prescription medications or devices utilized for weight loss) (you must also submit evidence of attendance of the program) - up to $700 per year;	
	FITNESS PROGRAMS - Active Member Only (can be individual classes or gym membership; evidence of attendance is required) - up to $700 per year;	
	LIFE INSURANCE PREMIUMS - Active Member Only - up to $700 per; and/or,	
	CANCER, SICKNESS OR ACCIDENT INSURANCE PREMIUMS (Non-Auto) - Active Member Only - up to $700 per year.	

TOTAL SHALL NOT EXCEED THE MAXIMUM REIMBURSEMENT OF UP TO $700 of out of pocket expenses that you incurred for one or any combination of the items listed above.	TOTAL DUE TO ME	

MEMBER'S SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, PROVIDER OR PHARMACIST TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS, WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL EXPENSES CLAIMED WERE THE EXPENSES INCURRED.

REIMBURSEMENTS ARE PAYABLE TO ACTIVE MEMBER ONLY

______________________________ MEMBER'S SIGNATURE

______________________________ DATE

FOR OFFICE USE ONLY

Check #: ________________

VERIFICATION SIGNATURE: __________________________ DATE _____/_____/_____

Check Issued Date: _____/_____/_____