Yonkers Federation of Teachers Welfare Fund

35 East Grassy Sprain Road
Suite 502
Yonkers, New York 10710

STATEMENT OF CLAIM FOR HEARING AID BENEFIT

MEMBER MUST COMPLETE THIS SECTION

Patient's Name	Relationship to Member ☐self ☐spouse ☐child ☐other			Patient's Birthday
Name of Member		Social Security Number		Date of Birth
Home Address	City	State	Zip Code	Home Phone
Name of School or Building Assignment		Date of Employment in Yonkers System		

Are Hearing Aid Benefits available from any other provider for this patient? ☐ YES ☐ NO
If **yes**, indicate the following and annex the original Explanation of Benefits from **primary** carrier, if **applicable**.

Spouse's Name:_____ Spouse's Social Security Number:_____

Spouse's Employer:_____ Spouse's Date of Birth:_____

Spouse's Benefit Plan(S) NO. and Insurer(S): _____

Note: The Fund pays up to a maximum of **$600** toward the cost of hearing aids once every 2 consecutive years for each eligible person. Refer to the Benefit Booklet published by the Fund for a complete benefit description.

This form, when completed, is to be mailed **With an original itemized receipt marked "Paid"** describing the appliance purchased, the date purchased, amount charged and name of the patient to: **Yonkers Federation Of Teachers Welfare Fund, 35 East Grassy Sprain Road, Yonkers, N.Y. 10710 Within 90 days of the date you received the services listed below.**

THIS SECTION TO BE COMPLETED BY PHYSICIAN, OTOLOGIST OR AUDIOLOGIST

Patient's Name_____
Date of most recent hearing test_____
Date last Hearing Aid prescribed for patient _____
Hearing Loss Percentage (%) Left ear_____ Right ear _____

Service Rendered and Charges:
Hearing Test and Analysis $_____
Hearing-Aid Fitting $_____
Hearing-Aid appliance $_____
Type or model_____
Total $_____

Signature _____
Office Address _____
Telephone Number _____

I certify that the forgoing information is true and correct. I understand I am financially responsible for any expense not covered by this benefit.

Date _____ Members Signature _____

FOR ADMINISTRATOR ONLY

MEMBER/DEPENDENT	AMOUNT PAID _____	FOR YEAR _____