GOSHEN TEACHER'S ASSOCIATION
BENEFIT TRUST FUND

REIMBURSEMENT PROGRAM CLAIM FORM

The reimbursement program is for any expenses incurred by the employee, his/her spouse, and/or eligible dependents. **These expenses cannot be reimbursed by any other plan.** Please complete all sections of the form, attach copies of your bills (dated between Oct 1 thru Sept 30) and return no later than 180 days after September 30 to:

Plan Administrators
Brown & Brown of New York Inc.
d/b/a Fitzharris & Company
333 Earle Ovington Blvd. Suite 215
Uniondale, NY 11553
Claim office telephone: 1-516-944-2823

Members Name____________________ Social Security Number____________
Address____________________________________

Name of Member or dependent	Service Category Number	Date of Service	Amount not covered by any other plan

Service Category Number:
1. Optical
2. Major Medical Deductible
3. 20% co-payment of the medical bill
4. Orthotic Devices
5. Hearing aids
6. Dental expenses
7. Medical expenses (not covered by/or in excess of any insurance plan)
8. Prescription co-payment
9. Other

Note:
(1) Please attach the copies of the bills and circle the amount not covered by any other plan.
(2) If the claim form is not completed and the services are not completely itemized, processing of payment will be delayed until all required information has been submitted.
(3) Orthotic devices and hearing aids must be submitted first to your health company and be rejected. Attach not only the bill but also the rejection letter from the health insurance form.

Revised October 1, 2016