CSEA EMPLOYEE BENEFIT FUND
HEARING AID CLAIM FORM

Claim form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached. *Incomplete claims will be returned.*

Mail completed claims to:
CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12210-0516

Last name of Member: ______________________________

First name of Member: __________________________ **EBF ID#:**________________

Member's mailing address:

Number & Street: ____Apt#____

City: __________________________________ State: ______ Zip Code: ____________

Daytime Phone # (   ) ______-_________ Employer: _________________________

Patient name: _____________________________________ **Relationship**___________

Please indicate if the hearing aid is for:

Left Ear ______ Right Ear______ Both Ears______

Member's Signature: _________________________________**Date**_____/____/____

Hearing Aid Benefit:

Submit for this benefit only if it has been negotiated for you under your collective bargaining agreement. For full details of your benefits, refer to your Summary Plan Description. Information can also be found by visiting our website.

This benefit reimburses an allowance toward the cost of a hearing aid, including charges for its fitting upon the recommendation of a physician. Reimbursement is processed up to the maximum benefit allowed per eligible patient. Submit your completed claim form with original receipts and a copy of your doctor's prescription. Hearing aid repairs, batteries and other non-durable equipment are not covered. All claims must be submitted by December 31st of the following calendar year.

CSEA Employee Benefit Fund
1-800-323-2732
www.cseaebf.com