IMPORTANT: PLEASE READ

Annual Physical Reimbursement

This claim form should only be used if you are an employee of:

Town of Southold

SUMMARY OF THE BENEFIT:

Maximum Reimbursement: $95

Submit your claim form along with an Explanation of Benefits (EOB) from your Health Insurance and a copy of your doctor’s bill.

Please refer to the detailed instructions on the claim form for more information. You can find our Annual Physical claim form on our website at www.cseaebf.com
CSEA Employee Benefit Fund

TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member’s Name __________________________________________ EBF ID# __________________________

Mailing Address __________________________________________ Apt # __________________________

City __________________________ State ______ Zip Code __________

Daytime Phone # __________________________ Email __________________________

Patient’s Name __________________________________________ Relationship __________________________

Date of Exam __________________________________________

Member’s Signature __________________________________________ Date __________________________

Please allow up to 6 weeks for processing.

MAIL COMPLETED CLAIM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516

MAJOR PLAN FEATURES

• Covers eligible employees and their spouse/domestic partner once every calendar year.
• The Fund will cover only that portion of the physical examination cost, up to $95, not reimbursable through other insurance or health plans.
• Examinations for a second opinion, Worker’s Compensation, or any other federal plan are not reimbursable.
• Reimbursement is made directly to the member.

INSTRUCTIONS

• Submit this form with a copy of your doctor’s bill and a copy of an Explanation of Benefits (EOB) from your primary health insurance.
• All claims must be submitted no later than December 31st of the following calendar year.
• Submit for this benefit only if it has been negotiated for you under your collective bargaining agreement.