



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	
<p>Are Hearing Aid Benefits available from any other provider for this patient? YES NO</p> <p>If yes, indicate the following and annex the original Explanation of Benefits from primary carrier, if applicable.</p> <p>Spouse's Name: _____ Spouse's Social Security Number: _____</p> <p>Spouse's Employer: _____ Spouse's Date of Birth: _____</p> <p>Spouse's Benefit Plan(S) NO. and Insurer(S): _____</p>		

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 _____	Service Rendered and Charges:
Date of most recent hearing test _____	Hearing Test and Analysis \$ _____
Date last Hearing Aid prescribed for patient _____	Hearing-Aid Fitting \$ _____
Hearing Loss Percentage (%) Left ear _____ Right ear _____	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 _____
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