WARWICK VALLEY TEACHERS BENEFIT TRUST

HEARING AID BENEFIT CLAIM FORM

Employee Name: ____

Address: ____

Last 4 digits Social Security #:______________________________

Unreimbursed charges for hearing aids.

Payment is limited to $200.00 over a two –year period within the plan years.

Be sure your bills and/or receipts are copied and attached. **Do not send originals.**
This completed claim form should be mailed to:

The Preferred Group
P.O. Box 15136
Albany, New York 12212-5136

Date(s): ______________ Total Amount of Claim: __________________

I certify that the above information is accurate and that the charges indicated were incurred by me or my dependents. I have not received payment for the amount of this claim from any other insurer, benefit fund, IRC 125 plan or by any other means.

_______________________________ ____________________
Members Signature Date