



**Brewster Teachers Association  
Welfare Fund Multi-Claim Form**

# Welfare Fund

## SUPPLEMENTAL BENEFIT MULTI CLAIM FORM

c/o The Preferred Group

P.O. Box 15136

Albany, NY 12212-5136

Phone 866-989-8997 FAX 518-641-0325

Patient Name		M	F	Patient Soc. Sec #		Patient DOB	
		<input type="checkbox"/>	<input type="checkbox"/>	- -			
Relationship to Member:	Self	Spouse	Child	Other	Work Phone		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	( )		
Member Name	Last	First	Middle Initial	Member Soc. Sec. #			
Address		City	State	Zip	Home Phone		
					( )		
<p>I certify that the information provided is correct and authorize the release of any information necessary to process this claim. Benefits are not available from any other source except as indicated above.</p> <p>Member Signature _____ Date _____</p> <p>Please coordinate benefits with _____ Soc. Sec. # _____ - _____ - _____ (this applies to individuals who have a spouse working within the district)</p>							

Check all that apply and attach receipts:	\$ Amount
<input type="checkbox"/> OPTICAL - Member/Dependents - \$400 Per person <b>in a two year period 9/1-8/31</b>	
<input type="checkbox"/> PROSTHETIC DEVICE - Member/Dependents - Balance paid in full after EOB.	
<input type="checkbox"/> AUDIO EXAM/HEARING AID - Member/Dependents - \$200 per person <b>every other</b> calendar year	
<input type="checkbox"/> MEDICAL SUPPLEMENTAL BENEFIT-\$500 per family per calendar year(**see below for elig. expenses for \$500 total)	
** INSURANCE DEDUCTIBLE	
** PHYSICAL EXAM	
** PSYCHIATRIC/FAMILY COUNSELING	
** MAMMOGRAPHY	
** CO-INSURANCE	
** MATERNITY	
** PRESCRIPTION DRUGS	

**See the reverse of this form for additional instructions in filing claims.**

Total

MULTIPLE CLAIMS MAY BE SUBMITTED USING THIS FORM. CAREFULLY ARRANGE RECEIPTS AND INCLUDE ALL EOB'S. ENCLOSE COPIES, NOT ORIGINALS. CHECK THE APPROPRIATE BOX TO THE LEFT OF EACH BENEFIT CATEGORY FOR EACH CLAIM.

CLAIMS MAY BE SUBMITTED TO PREFERRED GROUP PLANS, VIA FAX. MAKE SURE ALL CLAIM FORM COPIES AND ATTACHMENTS ARE LEGIBLE OR PAYMENT WILL BE DELAYED.

DO NOT SUBMIT DENTAL OR ORTODONTIA CLAIMS USING THIS FORM. ALL DENTAL CLAIMS MUST BE FILED ON A SEPARATE DENTAL FORM.

GOOD RECORDKEEPING WILL ENABLE MEMBERS TO TAKE FULL ADVANTAGE OF BTAWF BENEFITS.

ANY QUESTIONS REGARDING SUBMISSION OF CLAIMS MAY BE DIRECTED TO ANY TRUSTEE OR TO PREFERRED GROUP PLANS, DIRECTLY.

IF YOU EXPERIENCE A PROBLEM WITH THE PROCESSING OF A CLAIM, FIRST CONTACT PREFERRED GROUP PLANS, BEFORE CONTACTING A TRUSTEE OF THE FUND.

MEMBERS HAVE A RIGHT TO APPEAL THE DENIAL OF A CLAIM BY PREFERRED GROUP PLANS, BEFORE MAKING AN APPEAL, MEMBERS MUST CONTACT PREFERRED GROUP PLANS AND ATTEMPT TO RESOLVE THE ISSUE WITH PREFERRED GROUP PLANS. PLEASE CHECK THE BENEFIT BOOK FOR CLAIMS APPEAL INFORMATION.

ALL CLAIMS BY MEMBERS ARE STRICTLY CONFIDENTIAL. TRUSTEES OF THE BTAWF DO NOT REVIEW MEMBERS CLAIMS OR EOB'S AND ARE NOT PRIVY TO ANY MEMBER'S USAGE OF FUND BENEFITS. APPEALS ARE LIKEWISE KEPT CONFIDENTIAL. THE TRUSTEES GRANT OR REJECT APPEALS BASED ON FACTS PRESENTED BY THE MEMBER IN WRITING TO PREFERRED GROUP PLANS. THE MEMBER MAKING AN APPEAL WILL NOT BE MADE KNOWN TO THE TRUSTEES.