



White Plains Teachers Association – Welfare Trust Fund 2018 REIMBURSEMENT BENEFIT CLAIM FORM

Only Active & COBRA Members are eligible for this benefit

Member's Name: _____ SSN: _____ - _____ - _____

Member's Address: _____

Maximum Benefit: \$600.00

Services must be incurred between January 1, 2018 and December 31, 2018. Expense must be incurred by you, your spouse, or eligible dependent children and not reimbursed by any other insurance plan or benefit. Annual benefit amount listed above is **NOT** guaranteed in the future.

- ❖ **No claim will be accepted or processed by Zenith American prior to January 1, 2019.**
- ❖ **Zenith American must receive your claims by March 31, 2019.**
- ❖ **You can only make one submission for 2018 services.**

<u>Service Categories</u>			
D - Dental expense	M - Medical out of pocket/co-pay	P - Pharmacy out of pocket/copay	V - Vision Expense

Name of Member Or Dependent	Service Category (D, M, P, or V)	Date of Service	Amount not covered by any other plan
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Please attach the copies of the bills or Explanations of Benefits and circle the amount not covered by any other plan.

Signature

Date

You can make multiple copies of this form. Please complete all sections of this form, make a copy for yourself, and mail the original to:

WHITE PLAINS TEACHERS ASSOCIATION
c/o Zenith American Solutions
P.O. Box 5817
Wallingford, CT. 06492-7617