CSEA
AFSCME Local 1000, AFL-CIO
EMPLOYEE BENEFIT FUND

CSEA EMPLOYEE BENEFIT FUND CLAIM FORM

Use this form to claim CSEA Employee Benefit Fund benefits for

Physician Co-Pay **Prescription Drug Co-Pay**
Hearing Aid **Maternity**

Phone 800 323-2732

Claim Form must be completed and signed by the CSEA Employee Benefit Fund Member. All required documentation must be attached. ***Incomplete claims will be returned.***

Mail completed claims to:
CSEA Employee Benefit Fund
P.O. Box 516
Latham, NY 12110-0516

Last First Initial

Member Name

__ __ __ - __ __ - __ __ __ __
Social Security Number

Number & Street Apt. No. Village/Town/City State Zip Code

Member's Home Address

( ) __ __ __ - __ __ __ __
Member's Daytime Phone Number

Member's Employer

Member's Signature

Members' Health Insurance Carrier(s)

Spouse's Health Insurance Carrier(s)

Check The Benefit For Which You Are Submitting.

Claim only those benefits that have been negotiated for you under your collective bargaining agreement.

☐ **Physician Co-Pay**
Complete this claim form and submit with original receipts attached clearly indicating the co-pay amount when you have accumulated the maximum benefit allowed for the current calendar year. If you do not accumulate the maximum allowed, submit your claim after December 31st for what you did pay.
See Reverse For Important Information

☐ **Prescription Drug Co-Pay**
Complete this claim form and submit with original receipts or pharmacy printout attached when you have accumulated the maximum benefit allowed for the current calendar year. If you do not accumulate the maximum allowed, submit your claim after December 31st for what you did pay.
See Reverse For Important Information

☐ **Hearing Aid**
Complete this claim form and submit with *both* your paid bill *and* a copy of doctor's prescription.

☐ **Maternity**
Complete this claim form and submit with a *copy* of the child's birth certificate.

Separate Benefit Checks Are Processed For Each Benefit Claimed