SERGEANTS BENEVOLENT ASSOCIATION
HEALTH AND WELFARE FUND
35 WORTH STREET
NEW YORK, N.Y. 10013

Hearing Aid Reimbursement Claim Form

(See instructions on the rear of the form before completing)

Active_____ Retired_____

Member Tax # ____ ____ ____ ____ ____ ____

Member Name (Last, First) _____

Home Address_____

City, State, Zip Code_____

Telephone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

E-Mail Address_____

****Please attach an original itemized bill****

Patient Name _____Patient DOB _____/_____/_____

Relationship to Member: Self_____ Spouse/D.P._____ Son_____ Daughter_____

Ear: Left_____ Right_____ Both_____

Amount Submitted For Reimbursement $_____

Date of Claim _____/_____/_____

Is this patient eligible for any coverage that offers reimbursement for this hearing aid claim such as, but not limited to, union coverage, Medicaid, Medicare, supplemental health insurance, extended Durable Medical Equipment (D.M.E.) policy, which has or will in the future provide any reimbursement for this hearing aid claim? Yes_____ No_____

(Please describe coverage and note any and all reimbursement received)

_____

_____

I certify that this claim is submitted for authorized charges as described on the reverse side of this form and have attached an itemized bill confirming these charges. I have disclosed any and all reimbursement I have received or are eligible to receive for this hearing aid claim now or in the future. I fully understand I am obligated to notify the S.B.A. Health and Welfare Office if I receive any non disclosed reimbursement for this claim.

_____ _____/_____/_____

Member Signature **Date**

Plan Reimbursement:

Active and Retired Sergeants, Member Spouses, and Registered Domestic Partners

$500.00 stipend per device
Maximum Benefit $1000.00
Every four (4) years

Eligible Dependent Children

$1000.00 stipend per device
Maximum Benefit $2000.00
Every two (2) years.

Benefit Guidelines:

1. **Initial medical evaluation and approval for a hearing aid must be performed by a Board Certified Otolaryngologist.**

2. **Member must submit a signed letter from their Otolaryngologist on official letterhead outlining the detailed diagnosis and need for hearing aid. Members must also submit all test results including all Audiometric tests.**

3. **Requesting member must provide a paid itemized bill that reflects the qualified product purchased.**

4. **The claim must be submitted within one year of the purchase date.**

5. **All claims are subject to review for duplication, coordination of benefits, worker's compensation etc. At no time will the fund reimburse more than 100% of a claim cost.**

6. **The benefit does not cover the exam, repairs, batteries, accessories, and service contracts.**

7. **The fund will reimburse for ear molds, for children only, in lieu of a new device, under the same two year guidelines.**

8. **All completed forms should be forwarded to:**

S.B.A. Health and Welfare
35 Worth Street
New York, N.Y. 10013

Attn: Tony Amato