PREFERRED PG GROUP The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(866) 989-8997
View your Account Information Online
www.MyTPGPlan.com

CHAPPAQUA CTBF Reimbursement Form

WLT00754

HWTF00754

☐ Address/Contact Information Change Please correct information below

DIRECTIONS: Please submit completed forms to The Preferred Group at the above address or fax to (518) 641-0325.

Section 1 Employee Information

Employer Group #	Employer Group Name	Plan Year
00754	Chappaqua CTBF	7/1 to 6/30

Employee Name (First Name)	(Last Name)	SS ID (4 Digit)

Employee Address (Street, Apt. #)

Employee Address (City, State, Zip Code)

Home Phone	Cell Phone	Email Address (Please allow email from benefitsinfo@thepreferredgroup.com)

Section 2 Claim for Reimbursement—Please use Dental Form for any Dental Procedures

Service Types & Descriptions: (List the number of the Service Type in the claim lines below)

20 - Dental Reimbursement
44 - Vision Reimbursement

Please list the dates of service, the number of the service type, a brief description and amount in the area below. A receipt copy will be need to be attached to this claim.

All Reimbursements are Paid to the Participant

Service Date		Service Type #	Description	Amount of Claim	Office Use	
					☐	Code:
					☐	Code:
					☐	Code:
					☐	Code:
					☐	Code:
					☐	Code:
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Section 3 Signature and Acceptance of Plan Rules (Unsigned forms will not be accepted)

Please read and sign below: This is to certify that I have incurred the expenses listed above for myself, my spouse or qualifying dependents, that the expenses detailed above are eligible for reimbursement in accordance with applicable governmental rules and regulations, and that, in the case of medical claims, they are required to treat a medical condition. I further understand that I am solely responsible for the validity of my claims. I have retained originals or copies of all documents submitted including documentation of reimbursement to me provided by other health coverage. I understand and agree that since these expenses are to be reimbursed, they may not be claimed on my income tax. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health or benefit coverage (i.e. duplicate payments), I shall return the monies paid to me by this plan, for re-crediting to my account. I hereby request that the plan reimburse me for expenses identified in this voucher and attachments.

Participant Signature	Date