CHAPPAQUA CONGRESS OF TEACHERS BENEFIT FUND
REIMBURSMENT CLAIM FORM
BENEFIT YEAR: 07/01/16 – 06/30/17

Employee Name: ____ SS#:______-____-________

Address: ____

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Please attach copies of Explanation of Benefits (EOB's) from insurance companies and other receipts showing unreimbursed expenses being applied to the **$250.00** allowance.

Circle amount not covered on receipts/statements.

Benefit year: July 1, 2016 – June 30, 2017.

The claim filing period will begin **May 15, 2017 - September 30, 2017.**
Claim must be post marked no later than 09/30/2017 or claim will be denied for late filing.

SERVICE CATEGORIES:
1. Optical expenses (not paid by Vision Plan for Member/Dependent Member)
2. Dental expenses (not paid by Dental Plan for Member/Dependent Member)

Employee/Dependent	Serv. Cat. #	Service Date	Amt. Not Covered
		Total:	

Send this form to:

Brown & Brown of New York, Inc.
dba Fitzharris & Company
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Uniondale, NY 11553-3624
Tel (516) 777-4800
Fax (516) 944-2953