HARRISON ASSOCIATION OF TEACHERS BENEFIT TRUST FUND

Non-Contributory Flexible Benefit Program Claim Form

Please complete all sections of this form and submit it, with associated copies of receipts and necessary documentation (see below), to:

Harrison Association of Teachers Benefit Trust
c/o Preferred Group Plans
P.O. Box 15136
Albany, NY 12212-5136
Tel. 1-800-573-7474
Fax: (518) 641-0325

Member Name: ____ **Member SSN**: ________________________________

Name of Member Or Dependent	Service Category Number (*see below*)	Date of Service	Amount Not Covered By Any Other Reimbursement

Service Category Numbers:

1. Optical/Vision Expenses
2. Major Medical Deductible Expenses
3. Medical Co-pays
4. Orthotic Device Expenses
5. Hearing Aide Expenses
6. Dental Expenses of Member/Spouse/Dependent Not Covered by Any Other Dental Plan
7. Medical Expenses Not Covered by, Or In Excess Of, Any Insurance Plan
8. Prescription Drug Co-Pays

Please Note:

A. For expenses not covered by health/dental insurance, please attach copies of the Explanation of Benefits (EOBs) and circle the amount not covered by the plan(s)

B. For reimbursements associated with service categories 4 & 5: any claims for orthotic devices and hearing aids must be first submitted to your health insurance company before any medical insurance-denied coverage amounts will be reimbursed through this flex plan. You will need to attach a copy of documentation from your health insurance company providing evidence of denial of complete coverage of such expenses.

C. Please remember that this flex plan's year runs from July 1st through June 3oth. Maximal yearly reimbursement is **$300** per family plan enrollment ($150 maximum for any individual covered in a family enrollment) and **$150** per single plan member enrollment.

If you have any questions, please do not hesitate to contact a Harrison Benefit Trust Fund Trustee in your building.

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