CSEA
EMPLOYEE
BENEFIT FUND

IMPORTANT: PLEASE READ

Annual Physical Reimbursement

This claim form should only be used if you are an employee of:

Town of Southold

SUMMARY OF THE BENEFIT:

Maximum Reimbursement: $95

Submit your claim form along with an Explanation of Benefits (EOB) from your Health Insurance and a copy of your doctor's bill.

Please refer to the detailed instructions on the claim form for more information. You can find our Annual Physical claim form on our website at www.cseaebf.com

CSEA Employee Benefit Fund
Annual Physical Claim Form

Form must be completed and signed by the CSEA Employee Benefit Fund member. All required documentation must be attached.
Incomplete forms will be returned.

MAIL COMPLETED CLAIM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516

MAJOR PLAN FEATURES

- Covers eligible employees and their spouse/domestic partner once every calendar year.
- The Fund will cover only that portion of the physical examination cost, up to $95, not reimbursable through other insurance or health plans.
- Examinations for a second opinion, Worker's Compensation, or any other federal plan are not reimbursable.
- Reimbursement is made directly to the member.

INSTRUCTIONS

- Submit this form with a copy of your doctor's bill **and** a copy of an Explanation of Benefits (EOB) from your primary health insurance.
- All claims must be submitted no later than December 31st of the following calendar year.
- Submit for this benefit only if it has been negotiated for you under your collective bargaining agreement.

TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Daytime Phone # _____ Email _____

Patient's Name _____ Relationship _____

Date of Exam _____

Member's Signature _____ Date _____

Please allow up to 6 weeks for processing.