RETURN TO:
Doctors Council Welfare Fund
50 Broadway, Suite 1101
New York, NY 10004
Phone: 212-532-7690 Fax: 212-481-4137
Email: benefits@doctorscouncil.org

DOCTORS COUNCIL WELFARE FUND

COBRA REIMBURSEMENT BENEFIT CLAIM FORM

Members in the Office of School Health and Oral Health of the NYC Dept of Health and Mental Hygiene who are furloughed from their positions in the Summer are entitled to reimbursement every Plan Year (July 1 – June 30) for up to three (3) months of COBRA payments for City health insurance in an amount not to exceed that which the City would pay for health insurance without any employee contribution. (This does not include the high-option rider for which the employee would pay the cost.)

Covered Expenses include: Up to three (3) months of COBRA payments for City health insurance in an amount not to exceed that which the City would pay for health insurance without any employee contribution, not including the high-option rider for which the employee would pay the cost.

MEMBER INFORMATION

MEMBER NAME		BIRTH DATE	MALE FEMALE		
ADDRESS	APT. NO.		CITY	STATE	ZIP CODE
U.S. SOCIAL SECURITY NO.											DAYTIME TELEPHONE NUMBER		
EVENING TELEPHONE NUMBER			AGENCY OR DEPARTMENT	WORK LOCATION	
JOB TITLE			FULL-TIME PART-TIME SESSIONAL		

HOW TO FILE A CLAIM

(1) **Complete the claim form and return it to the Fund Office with proof of payment(s) and a copy of the billing statement(s) from the health insurance provider**

(2) **All claims for benefits must be postmarked, if mailed or received no later than 1 (one) year after your last payment of COBRA premiums for that Summer**

FAILURE TO FILE REQUIRED DOCUMENTATION AND/OR SIGN EACH CLAIM FORM WILL CAUSE DELAY IN THE PROCESSING OF YOUR CLAIM, AND MAY CAUSE A DENIAL OF YOUR CLAIM.

IMPORTANT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

REIMBURSEMENTS ARE PAYABLE TO MEMBERS ONLY

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SIGNATURE OF MEMBER DATE