



**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.cseabf.com](http://www.cseabf.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.*