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J.J. Stanis and Company, Inc.
100 Jericho Quadrangle, Suite 101
Jericho, NY 11753

Education Association of South Orangetown

BENEFIT FUND CLAIM FORM

Social Security No _____ Phone No _____

Employee Name _____
Last First Middle Initial

Attach a copy of the Explanation of Benefits (EOB) you receive from vision, dental and health care plans. For each attached EOB: list provider, the date of service and the amount not paid by the insurance in the CLAIM INFORMATION section. If you submitted the expense to insurance plans, attach EOB's from both plans. If the expenses are not covered by your insurance plan, attach a copy of the bill to the insurance statement denying benefit

QUALIFYING EXPENSES

Date Incurred	Name of Service Provider	Person for Whom Expense Incurred	Amount After Reimbursement
		TOTAL	

READ CAREFULLY:

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during the period while the undersigned was covered under the Benefit Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable under any other insurance plan coverage. The undersigned fully understands that he or she alone is fully responsible for sufficiency, accuracy, and the veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to said expense.

_____ _____
Employee signature Date

(over)