J.J. STANIS AND COMPANY, INC
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EASO Education Association of South Orangetown Benefit Fund Claim Form

Return completed form by Mail, E-mail: claims1@jjstanisco.com, or Fax

Employer _____

Employee Name _____ Member ID # _____
Last Middle First

Home Address _____
Number/Street City State Zip

☐ Please check only if this is a new address. Daytime Telephone Number _____

Check the box that applies. Supporting documentation as required by the IRS, applicable laws and/or your Plan must accompany this reimbursement request form.

◯ **I have group health (medical, dental, vision) insurance for this expense.** Attach a copy of the Explanation of Benefits (EOB) statement that you received from your insurance carrier showing how benefits were paid.

◯ **I do NOT have insurance coverage for this expense.** Submit an itemized statement showing the date of service, provider's name, services provided, and the amount of the charge.

1. Attach a copy of the Explanation of Benefits (EOB) you receive from your vision, dental and healthcare plan. For each additional EOB, list the provider, the date of service and the amount not paid by the insurance carrier in the Claim information section. If you submitted the expense to multiple insurance plans, attach EOB's from both plans. If the expenses are not covered by the insurance plans, attached a copy of the itemized bill along with the EOB denial form. **Any missing information from this claim form or the supporting documentation will delay reimbursement**.
2. Employees can file a claim form 4 times during the plan year – April, July, October and December. All claims for the prior benefit year must be filed by April 1 of the next year.
3. Employees who have terminated must file a form for claims incurred prior to termination within one month after the date of termination.
4. Make sure you file separate claim forms for different plan years.

Date of Service	For the Benefit of (Employee Name)	Description of Service	Provider of Service	Requested Amount
			TOTAL	

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

Employee Signature: _____ **Date:** _____