J.J. STANIS AND COMPANY, INC
377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530
PHONE: (516) 465-3900 FAX#: (516) 465-3920 WEBSITE: WWW.JJSTANISCO.COM

Middle Country CSD Supplemental Plan 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.

Reminders:

1. Provide an EOB for all expenses submitted
2. Sign and date the reimbursement form – J.J. Stanis cannot process an unsigned form
3. Multiple expenses may be included on one form. If more space is needed, attached additional signed forms
4. Keep copies of everything submitted.
5. A time saving tip – request a prescription printout from your pharmacy that lists all necessary information, eliminating the need to keep prescription stubs

Date of Service	For the Benefit of (Employee Name)	Description of Service	Amount Paid	Reimbursement 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:** _____