

The Exempt Firemen's Benevolent Fund Association
Village of Elmsford, N.Y.

Claim Form

DESCRIPTION: The Claim Form is to be used when you are claiming benefits for services and/or expenses incurred while being treated by a legally qualified and licensed Physician, Chiropractor, Optometrist, Ophthalmologist or Dentist or you are hospitalized. Claims for expenses, including co-pay, prescriptions, glasses, contact lenses, and frames (except for sunglasses) are qualified for a combined benefit.

INSTRUCTIONS: All instructions must be carefully followed and all blanks must be filled in. Failure to properly complete this form could result in delay or loss of benefits. All claims must be submitted no later than March 31st of the year following the year in which the service was provided. A copy of the Original Bill must be attached with this form upon submission.

Member: _____ Date: _____

Claim for: Self Family member (provide info below) Claim Amount \$ _____

Family member's name: _____

Medical Treatment Date of treatment _____

Hospitalization Date admitted _____ Date released _____

Care Provider's Statement

Care Provider's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Description of Service: _____

Care Provider's Signature: _____ Date: _____

I (member signature) _____ on this date _____

hereby avow the information provided is accurate and complies with Benevolent rules.

Benevolent Office Use Only – processed

Yes Date: _____ BOD Members: _____

No - Reason: _____

Claim returned to member by: _____