

Westchester C.O.B.A Welfare Fund
Hearing Aid Reimbursement Claim Form

Employee Name: _____ Active: Retired:

Address: _____

Phone #: _____

Payment is limited to \$500.00 per ear per member in a five year period. This benefit is only for the **Active/Retired Correction Officer**.

Be sure your bills and receipts are copied and attached. **Do not send originals.** This completed form can be mailed to:

Westchester C.O.B.A Welfare Fund
PO BOX 231
Thornwood, N.Y. 10594

Right Ear Audio Exam Date: _____

Left Ear Audio Exam Date: _____

Dr. Name: _____

Address: _____

Phone #: _____

I certify that the above information is accurate and that the charges indicated were incurred by me. I have not received payment for the amount of this claim from any other insurer, benefit fund, IRC 125 plan or by any other means.

Members Signature

Date