Annual Medical Reimbursement Request

Keep your receipts for eyeglasses, hearing aids, medical copays, prescription copays, and dental expenses. Fill out this form and submit when you have reached the **maximum of $200** OR by October of each year.

Name: _____

Address: _____

_____

Email: _____

Mail to:

PJS Terryville Benevolent Association
19 Jayne Boulevard
Port Jefferson Station, NY 11776

Expenditure Type	Amount	Proof of request attached
Pharmacy prescription drug copay		Pharmacy printout ☐
Medical copay (ER visit, doctor visit, hospital stay)		Medical bill showing amount covered by insurance/remainder ☐
Prescription Eyeglasses		Proof of balance not covered by insurance/Prescription required ☐
Dental expenses		Dental bill showing amount covered by insurance/remainder ☐
Hearing Aids		Prescription required/proof of amount not covered by insurance ☐
Other: Describe		May require discussion prior to approval
Total reimbursement requested:		**Date submitted:**

I attest that my request for reimbursement are for expenses NOT covered by insurance or a medical plan.

Requestor's Signature _____

Death Benefit – up to $15,000 paid to funeral home (requires copy of death certificate, covers expenses NOT covered by life insurance)
Financial Assistance – requires proof of need