BRONXVILLE EMPLOYEES' BENEFIT TRUST
TRUST ADDITIONAL BENEFIT (TAB)

MEMBER NAME: (print last name first)	SEX M F	MEMBER SS# - -	MEMBER DATE OF BIRTH Mo. Dy. Yr,
HOME ADDRESS: Number and Street		Apt.	HOME PH# (Area Code)
CITY	STATE		ZIP

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER SIGN HERE_____ **Date** _____

Please include copies of co-pay/prescription/deductible receipts and/or explanation of benefits denoting out-of-pocket expense for dental, vision, medical co-pays and prescription drug co-pays. General health items such as vitamins, gym membership, most over the counter items and non prescription sunglasses are NOT ELIGIBLE. Reimbursements cannot be provided without complete receipts.

SUBMISSION FOR PLAN YEAR JULY 1, 2017 THROUGH JUNE 30, 2018
REIMBURSEMENT MAXIMUM $100 PER FAMILY

	DATE	EXPENSE	AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
		TOTAL AMOUNT	

RETURN THIS FORM TO:
Preferred Group Plans, Inc.
P.O. Box 15136, Albany, NY 12212-5136
Tel. 1-866-989-8997 Fax 518-641-0325