

**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, 2019 THROUGH JUNE 30, 2021

REIMBURSEMENT MAXIMUM \$250 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:
STIRLING BENEFITS
291 S. LAMBERT ROAD SUITE 4
ORANGE, CONNECTICUT 06477
Tel. 1-203-876-1660 Fax 203-876-1465
claims-stirling@90degreebenefits.com