RETIREE

GREAT NECK TEACHERS ASSOCIATION BENEFIT TRUST FUND
EXCESS MEDICAL BENEFIT CLAIM FORM

MAIL CLAIMS TO:
THE PREFERRED GROUP
PO BOX 1536
ALBANY, NY 12212
HELP LINE:(866) 989-8997
FAX (866) 539-1394

Patient's Name: (Last) (First) (Middle)	Patient's Date of Birth	Patient's Social Security Number
Member's Name: (Last) (First) (Middle)	Member's Date of Birth	Member's Social Security Number
Mailing Address: (No. and Street/Apt. No.) City, State and Zip		Has Address Changed ☐ Yes ☐ No

Is your spouse employed? ☐ Yes ☐ No	If Yes, give name and address of your spouse's employer	Spouse's Date of Birth
Are benefits available from any other group insurance carrier for this patient? ☐ Yes ☐ No	Subscriber Name, ID # and Carrier	

BENEFITS ARE PAYABLE TO MEMBER ONLY

I CERTIFY THAT THE INFORMATION GIVEN IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT AVALIABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.

MEMBER SIGNATURE _____ DATE _____

Mark the benefit(s) for which you are applying: PLEASE ATTACH the explanation of benefits from the Empire Plan (United Health Care-Blue Cross), or any other group coverage along with applicable receipts and supporting documents.

☐ **VISION CARE BENEFIT** – Provides a maximum of $250 per insured person once every 2 policy years.

☐ **OUT-PATIENT PSYCHIATRIC BENEFIT*** – Pays up to $25.00 per visit for out-of-network provider. Reimburses co-payment up to $25.00 for in-network provider.

☐ **PATIENT REHABILITATION BENEFIT*** – Pays up to $600 with an additional 1% of all out-patient rehabilitations costs. Provided on a first dollar basis and coordinated with the Empire Plan (United Health Care-Blue Cross).

☐ **IN-HOSPITAL CASH BENEFIT*** – Provides MEMBER or SPOUSE up to $50/day, to a maximum of 7 day for in hospital only.

☐ **IN-HOSPITAL PRIVATE DUTY NURSING BENEFIT*** – Provides 50% of the Usual and Customary charge for the first 48 hours of private duty nursing/hospitalization.

☐ **OUT OF NETWORK – DEDUCTIBLE BENEFIT*** – Pays up to and including $400 of your annual Out-of-Network Deductible for the participant and/or family with an additional 1% of all deductible costs incurred in that same year.

****CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE ON THE EMPIRE EXPLANATION OF BENEFTIS****

**** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE FUND OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTUAL MATERIAL, THERETO, COMMITS A FRAUD, WHICH IS A CRIME****