MAIL TO: **Administrative Services Only, Inc** PO Box 9005 Lynbrook, NY 11563-9005 516-396-5500 / 800-537-1238 **WWW.ASONET.COM**		**NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND CLAIM FORM FOR RETIRED MEMBERS**

Please visit www.njdcea.org for additional plan information and claim forms
Please visit www.asonet.com to track your claims and claim history
Please note deadline to file claim is: **April 30th** of the following plan year.

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE ☐ FEMALE ☐		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
U.S. SOCIAL SECURITY NO.		DAYTIME TELEPHONE NUMBER EVENING TELEPHONE NUMBER		

PATIENT INFORMATION

PATIENT NAME	BIRTH DATE	MALE ☐ FEMALE ☐	RELATIONSHIP TO RETIRED MEMBER SELF ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ CHILD ☐

CLAIM INFORMATION-PLEASE ATTACH EXPLANATION OF BENEFITS FROM ALLCARRIERS AND RECEIPTS

CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES	

- ☐ **Hospital Indemnity Benefit-** $50 per night for first 30 nights per Retiree and Spouse. Family maximum of $1,500 per calendar year.
- ☐ **Emergency Room Reimbursement Benefit-** Reimbursement of up to $100 per visit to hospital emergency room per Retiree and Spouse. Reimbursement of up to $50 per Dependent Child. Family maximum is $500 per year.
- ☐ **Prescription Drug Reimbursement Benefit-**Up to $60 per prescription copay for Retirees, Spouses, and Dependents. Family maximum is $350 annually.
- ☐ **Cancer Screening Reimbursement Benefit-** Reimbursement of up to $50 per year per Retiree for any out of pocket costs for a mammogram, PSA exam, or colonoscopy.

IMPORTANT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME PUNISHABLE BY FINE, IMPRISONMENT OR BOTH.

MEMBER SIGNATURE – REIMBURSEMENT PAYABLE TO MEMBER ONLY

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF OR ANY OF MY DEPENDENTS WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED. I HEREBY CERTIFY THAT I AM ENROLLED IN A GROUP HEALTH PLAN THAT MEETS MINIMUM VALUE STANDARDS UNDER THE AFFORDABLE CARE ACT. I AM SUBMITTING A COPY OF MY GROUP HEALTH PLAN ID CARD FOR THAT COVERAGE ALONG WITH THIS REIMBURSEMENT CLAIM.

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SIGNATURE OF MEMBER   DATE