Administrative Services Only, Inc
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NINTH JUDICIAL DISTRICT COURT EMPLOYEES ASSOCIATION BENEFIT FUND

HEARING AID REIMBURSEMENT FORM

Please visit www.njdcea.org for additional plan information and claim forms
Please visit www.asonet.com to track your claims and claim history

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	MALE ☐ FEMALE ☐		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO. OR LAST FOUR DIGITS	WORK LOCATION	DAYTIME TELEPHONE NO :	EVENING TELEPHONE NO:	
| | | | | | | |				

Active Members and Dependents are entitled to up to $1000 every three years towards the purchase or repair of a hearing aid only that is prescribed for you by a doctor.

Retired Members are entitled to up to $600 every three years towards the purchase or repair of a hearing aid only that is prescribed for you by a doctor.

The Fund has also arranged for Covered Members, to have access to Amplifon Hearing Health Care which is designed to provide cost savings to those participants in need of hearing aids. While you do not need to get your hearing aid from Amplifon in order to access the Fund's benefit, doing so might help your benefit go further.

Even though spouses and dependents are **NOT** eligible for benefits under the hearing aid reimbursement plan, they may take advantage of the discounts provided by Amplifon.

Access to Amplifon's Hearing Discount program includes the following benefits:

- Discounted hearing testing
- Low price guarantee - bring Amplifon the local quote and they will better it by 5%
- 3-year warranty
- 60-day risk-free trial
- 2 years free batteries
- One year free follow-up care

To take advantage of the Amplifon Network:
Call Amplifon at 1-888-484-7554 and their Patient Care Advocate will help you find a hearing care provider near you. The Patient Care Advocate will explain the details of the Amplifon Program, help identify a local hearing care provider and assist you with making an appointment. They will send you and your provider the necessary information to activate your Amplifon program.

TO FILE FOR REIMBURSEMENT COMPLETE, SIGN AND RETURN THIS FORM TO ASO ALONG WITH A COPY OF YOUR PROVIDER RECIEPTS

MEMBER SIGNATURE – BENEFIT WILL BE PAID TO THE MEMBER

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED, AND ARE NOT REIMBURSABLE UNDER ANY OTHER PLAN COVERAGE AND THAT I AM ENTITLED TO THIS BENEFIT AND THAT I AM ENTITLED TO THIS BENEFIT.

_____ _____
SIGNATURE OF MEMBER DATE