SHERIFF OFFICERS BENEFIT FUND
CLAIM FORM

Please enclose original copy of receipts for out-of-pocket expenses and enter below the amount and type of claim.

All receipts and/or statements must show:

- ☐ Date of Service
- ☐ Doctor or clinic name
- ☐ Type of service provided
- ☐ Charge for the claimed services.

All Prescription claims must show:

- ☐ Name of the Drug
- ☐ RX#
- ☐ Date Received
- ☐ Prescribing Doctor
- ☐ Cost

☐ MEDICAL CLAIM $_____

☐ DENTAL CLAIM $_____

☐ PRESCRIPTION CLAIM $ _____

☐ EYE CARE CLAIM $ _____

All Claims are for members only, not for family or dependents. Claims must be incurred while you are an active or retired Benefit Fund Member.

Medical claims must be for required services not elective. If this is a Chiropractic claim, be sure to include documentation to prove authorization from primary care physician.

ALL CLAIMS MUST BE SUBMITTED WITHIN YOUR CURRENT BENEFIT YEAR

DATE SUBMITTED: _____

SIGNATURE: _____
(Required)

*All claims are subject to the Benefit Fund Association's By-Laws in effect at the time of the claim submission.

For Office Use Only
Date: _____
Paid $:_____
Check #:_____