

SHERIFF OFFICERS BENEFIT FUND
CLAIM FORM

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

All receipts and/or statements should show date of service, doctor's or clinic name, type of service provided and charge for the claimed services. Prescription claims should show the name of the drug, date received, prescription number, prescribing doctor's name, and 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, i.e. by the last date of the month in which your benefit year ends. If you are unsure of your benefit year dates, please contact a Benefit Fund Board member.

DATE SUBMITTED: _____

SIGNATURE: _____

(Required)

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