Arlington Teachers' Association Welfare Trust Benefit Fund
Hearing Aid Benefit Claim Form

MAIL TO: ARLINGTON TEACHERS' ASSOCIATION
C/O PREFERRED GROUP PLANS, INC.
PO BOX 15136
ALBANY, NY 12212-5136
(800) 573 - 7474
(518) 641 – 0321

ATA WELFARE TRUST BENEFIT FUND
HEARING AID BENEFIT CLAIM FORM

Member's Name: _____

Member's Phone Number: _____

Member's Address: _____

_____

Member's Social Security # (*optional*): _____

There is a $500 benefit per family every 36 months. Eligible expenses include hearing aids, batteries, and adjustments. Be sure your bills and/or receipts are copied and attached. **Do not send originals.**
This completed form should be mailed to:

Arlington Teachers' Association
c/o The Preferred Group
PO Box 15136
Albany, NY 12212-5136

OR emailed to claims@tpgplans.com

Date(s): _____ Total Amount of Claim:_____

I certify that the above information is accurate and that the charges indicated were incurred by me or my dependents. I have not received payment for the amount of this claim from any other insurer, benefit fund, IRC 125 plan, or by any other means.

_____ _____
Member's Signature Date