Arlington Teachers' Association Welfare Trust Benefit Fund
Personal Health Care 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
PERSONAL HEALTH CARE CLAIM FORM

MEMBER'S NAME _____
LAST FIRST MIDDLE

MEMBER'S HOME ADDRESS _____

_____

_____

_____

MEMBER'S PHONE NUMBER _____

MEMBER'S SOCIAL SECURITY NUMBER (OPTIONAL) _____

AMOUNT OF CLAIM SUBMITTED (**$425.00 & THEN $1 PER VALID CLAIM**) $ _____

EMPLOYEE SIGNATURE _____

PLEASE MAKE CERTAIN YOU ATTACH A COPY(S) OF YOUR MEDICAL INSURANCE CLAIM REPORT OR REPORTS INDICATING YOUR UNREIMBURSED EXPENSES. THE BENEFIT FOR PERSONAL HEALTH IS $425 & $1 PER VALID CLAIM AFTER THAT FOR THE FISCAL PERIOD BEGINNING OCTOBER 1ST AND ENDING SEPTEMBER 30TH OF ANY GIVEN YEAR. CLAIMS MUST BE FILED NO LATER THAN THREE MONTHS FOLLOWING THE END OF THE FISCAL PERIOD.

PLEASE RETURN THIS COMPLETED FORM (ALONG WITH ATTACHED RECEIPTS) TO: ARLINGTON TEACHERS' ASSOCIATION, C/O PREFERRED GROUP PLANS, INC., PO BOX 15136, ALBANY, NY 12212-5136 **OR** EMAIL TO: CLAIMS@TPGPLANS.COM

NOTE: DENTAL and STANDARD VISION EXPENSES MAY NOT BE REIMBURSED USING YOUR PERSONAL HEALTH ACCOUNT