HOUSE STAFF BENEFITS PLAN

520 EIGHTH AVENUE, SUITE 1200, NEW YORK, NY 10018-4181
Phone: (212) 356-8180 **Fax: (212) 356-8181** **benefits@cirseiu.org** **http://www.cirseiu.org**

HEARING AID BENEFIT FORM

Eligibility**:** HSBP employees including eligible dependents.

Maximum reimbursement allowed: A lifetime maximum of $1,500 per ear to cover the cost of a hearing aid. In no way will the reimbursement be more than what was paid out of pocket.

Claim Submission Rules:

- Entire claim form must be completed in full by participant, patient or parent, if minor.
- A separate claim form must be submitted per patient.
- The need for a hearing aid must be approved by a certified audiologist and a letter from the audiologist must be submitted with the bill.
- All claims must be submitted to our office at the above-mentioned address within one year of the date of service. Claims submitted after one year will be denied.
- Please enclose the original bill with this form. The bill must state the participant's name and address, patient's name, relationship to House Staff Officer, date of service and amount of purchase. No photocopies, charge receipts or cancelled checks can be considered for reimbursement.

Please complete the following:

Participant's Name: ______________________________ ___________________________________
(Last Name) (First Name)

Social Security No.: ____________________ Hospital where employed: ____________________

Home Address: ____

______________________________ __________________________ _______________________
(City) (State) (Zip code)

Contact phone number: _____________________ Type (home, mobile, etc.) _________________

E-mail address: _____________________________

Patient's Name: ____________________________________ ________________________________
(Last Name) (First Name)

Relationship to participant: ___________________________

Patient's Signature or parent, if minor: __________________________ Date: _________________

(3/1/10)