EASO
Education Association of South Orangetown
Benefit Fund Claim Form

Return completed form to:
J.J. Stanis & Company, Inc.
377 Oak Street Suite 406
Garden City, NY 11530
Fax Number 1-516-465-3920

Email claims to: claims1@jjstanisco.com

Employer ____

Employee Name ____ Mbr No. ______________________
Last First Middle

Home Address: ____
Number/Street City State Zip

☐ Please check only if this is a new address. Daytime Telephone Number ______________________

1-Attach a copy of the Explanation of Benefits (EOB) you receive from your vision, dental and healthcare plan. For each additional EOB, list the provider, the date of service and the amount not paid by the insurance carrier in the Claim information section. If you submitted the expense to multiple insurance plans, attach EOB's from both plans. If the expenses are not covered by the insurance plans, attached a copy of the itemized bill along with the EOB denial form. **Any missing information from this claim form or the supporting documentation will delay reimbursement.**
2- Employees can file a claim form 4 times during the plan year – April, July, October and December. All claims for the prior benefit year must be filed by April 1 of the next year.
3- Employees who have terminated must file a form for claims incurred prior to termination within one month after the date of termination.
4-Make sure you file separate claim forms for different plan years.

Date of Service	For the Benefit of (Employee Name)	Description of Service	Provider of Service	Requested Amount

READ CAREFULLY: The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during the period while the undersigned was covered under the Benefit Plan with respect to such expenses and that the expenses have not been reimbursed and are not reimbursable under any other insurance plan coverage. The undersigned fully understands that he or she alone is fully responsible for sufficiency, accuracy and the veracity of all information relating to this claim which is provided by the undersigned and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relates to said expense.

Employee Signature: ____ Date: ______________

If you have questions about a claim, please call **(516) 465-3900** between 8:30 a.m. and 5:00 p.m. ET, Monday through Friday.