New York State Correctional Officers & Police Benevolent Association, Inc.

Retiree Dental Reimbursement Program
Reimbursement Claim Form *for Chapter Members and Dependents*

The NYSCOPBA Retiree Dental Reimbursement Program allows an eligible NYSCOPBA **Retiree Chapter Member reimbursement of up to $100** for Members and **$50 for dependents** (spouse, domestic partner and child(ren) up to age 23) for paid dental services (excludes dental premiums) from a provider of your choice. The reimbursement will be based upon the original paid receipt. You have until March 31st to file a claim for the previous year.

Member Information

(PLEASE PRINT CLEARLY)

Member Name:_____ Date of Birth: _____
First Middle Initial Last

Mailing Address: _____
Street City State Zip

Phone:_____ Email: _____
Area Code

Patient Information

Patient Name: _____
First Middle Initial Last

Relationship: Member Spouse DOB:_____ Child DOB: _____ Reimbursement up to age 23 for Child

Provider Information

Name of Dental Provider:

Name:_____

Address:_____

City:_____ State: _____ Zip: _____ Phone Number: _____

IMPORTANT NOTE: The Members/Dependents name must be listed on the original paid receipt and submitted with the claim form. Reimbursement will NOT be made unless the original receipt is attached.

TOTAL REQUESTED REIMBURSEMENT: $_____

Member

I hereby certify that the information provided is true and accurate and the receipt attached is the original copy for the expenditure for which I request reimbursement. **Additionally, I have read and understand the fraud statement on the back of this form.**

Member Signature: _____ Date: _____

MAIL YOUR COMPLETED CLAIM FORMS & ORIGNAL PAID RECEIPT TO:
Norvest Financial Services, Inc. | 930 Albany Shaker Rd. | Latham, NY 12110
For questions please call 1-888-869-8252

FRAUD STATEMENT

Any person who knowingly and with intent to defraud and deceive NYSCOPBA's Retiree Dental Reimbursement Program and submits an application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In **Florida**, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In **New Jersey**, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In **New York**, applicants for Accident and Health Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In **Kentucky** and **Pennsylvania**, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In **Tennessee,** state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.