CARMEL TEACHERS ASSOCIATION WELFARE TRUST FUND

MEMBER NAME: (print last name first)	SEX M F	MEMBER ID# - -	MEMBER DATE OF BIRTH Mo. Dy. Yr.
HOME ADDRESS: Number and Street		Apt.	HOME PH# (Area Code)
CITY STATE	ZIP		EMPLOYER PH# (Area Code)

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER
SIGN HERE____ **Date**

SUPPLEMENTAL FLEX
JULY 1, 2011 – JUNE 30, 2012

The Benefit reimburses members (***active and retired teachers only***) and eligible dependents up to a family maximum of $400.00 per Plan Year for the out-of-pocket expenses not covered under another insurance program.

Please include copies of co-pay receipts and/or explanation of benefits deno ting your out-of-pock et expense for dental, vision and prescription drugs.
Cash register receipts must have name of product purchased or will not be accepted.
You have 30 days (July 31, 2012) after the plan year ends to submit claims for 7/1/11-6/30/12 plan year.

	DATE	SERVICE	AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			
9			
		TOTAL AMOUNT	

RETURN THIS FORM TO:
Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
Tel. 1-800-573-7474 - Fax 518-641-0325