GREENBURGH TEACHERS FEDERATION WELFARE FUND
WELLNESS BENEFIT CLAIM FORM

MEMBER NAME: (print last name first)	SEX M F	LAST 4 OF SS#	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

GYM MEMBERSHIP

The Benefit reimburses members and eligible dependents up to a family maximum of $200.00 per Plan Year for the out-of-pocket expenses not covered under another insurance program for gym membership.

Receipts must have date of service and facility name or they will not be accepted.
You have 90 days (September 30, 20) after the plan year ends to submit claims for 7/1/ -6/30/ plan year.

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

RETURN THIS FORM TO:
The Preferred Group
P.O. Box 15136
Albany, NY 12212-5136
Tel. 1-866-989-8997 - Fax 518-641-0325