VOLUNTEER AND EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION

VALHALLA, N. Y.

Incorporated 1940

MEMBER
WESTCHESTER COUNTY
VOLUNTEER FIREMEN'S
ASSOCIATION

VALHALLA, NEW YORK 10595

MEMBER
NEW YORK STATE
VOLUNTEER FIREMEN'S
ASSOCIATION

TO: ALL VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION
FROM: Richard Zerbo, Treasurer/Benevolent
RE: **2024 co-payment/prescription reimbursement**
DATE: January 1, 2025

The Benevolent Trustees unanimously voted to start the co-payment/prescription reimbursement. This year the amount of reimbursement will be **$400.00** per Benevolent member for the plan year 2024. Enclosed you will find the co-payment/prescription reimbursement form, **which must be completed and mailed to:** VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION, 330 Columbus Avenue, Valhalla, NY 10595 **and postmarked no later than May 1, 2025.**

Please be advised that the reimbursement **only** applies to co-payments for doctor/ER visits and co-payments for prescriptions. Doctor/ER visits or prescriptions must have been provided/purchased in 2024. **Valid proof of payment** must be provided in order to be reimbursed. Acceptable proofs of payment are:

- Receipts
- Copy of canceled check
- Prescription print-out from pharmacy
- Dr. office print-out showing proof of payment(s) made
- Copy of Bank/Credit Card statement showing payment(s) made

An Explanation of Benefits (EOB) from any insurance provider is NOT proof of payment.

If you have any questions on this matter, or need additional forms, please contact:
Richard Thomas, President, 914-620-4922.

VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION
Co-Pay/Prescription Reimbursement Claim Form

CHECK ONE: ACTIVE_____ RETIRED_____

_____ _____

MEMBER NAME (print first and last name) **PHONE NUMBER**

_____

FULL HOME ADDRESS

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

MEMBER SIGNATURE _____

Valid proof of payment must be provided in order to be reimbursed. These include: copies of co-pay/prescription receipts, prescription printout from your pharmacy, Doctor and or ER visit printout that shows payment(s) made, copy of bank or credit card statements or copy of canceled check, as proof of payment. **Explanation of Benefits (EOB) from your insurance carrier is NOT an acceptable proof of payment.**

CLAIMS WILL ONLY BE PROCESSED FROM MARCH 1, 2025 -MAY 1, 2025.
CLAIMS POSTMARKED AFTER MAY 1, 2025 WILL NOT BE CONSIDERED.
$_____ REIMBURSEMENT MAXIMUM PER MEMBER

	DATE	EXPENSE	AMOUNT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			

Use next page for additional submissions

PLEASE RETURN FORM AND PROOF OF PAYMENT TO:
VOLUNTEER & EXEMPT FIREMAN'S BENEVOLENT ASSOCIATION
330 COLUMBUS AVENUE
VALHALLA, NY 10595

	DATE	EXPENSE	AMOUNT
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			

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VOLUNTEER & EXEMPT FIREMAN'S BENEVOLENT ASSOCIATION

330 COLUMBUS AVENUE

VALHALLA, NY 10595