

**VOLUNTEER
AND
EXEMPT**



VALHALLA, NY

Incorporated 1940

MEMBER
WESTCHESTER COUNTY
VOLUNTEER FIREMEN'S
ASSOCIATION

330 COLUMBUS AVENUE
P.O. BOX 81
VALHALLA, NEW YORK 10595

**FIREMEN'S
BENEVOLENT
ASSOCIATION**

MEMBER
NEW YORK STATE
VOLUNTEER FIREMEN'S
ASSOCIATION

TO: ALL VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION
FROM: Richard Zerbo, Treasurer
RE: **2025 co-payment/prescription reimbursement**
DATE: January 1, 2026

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 2025. Enclosed you will find the co-payment/prescription reimbursement form, **which must be completed and mailed or dropped off to to:**

VOLUNTEER & EXEMPT FIREMEN'S BENEVOLENT ASSOCIATION
330 Columbus Avenue,
Valhalla, NY 10595

and postmarked no later than March 1, 2026.

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 2025. **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, 2026 -MARCH 15, 2026.

CLAIMS POSTMARKED AFTER MARCH 15, 2026 WILL NOT BE CONSIDERED.

\$400 REIMBURSEMENT MAXIMUM PER MEMBER

| | <u>DATE</u> | <u>EXPENSE</u> | <u>AMOUNT</u> |
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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**

| | <u>DATE</u> | <u>EXPENSE</u> | <u>AMOUNT</u> |
|----|-------------|----------------|---------------|
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PLEASE RETURN FORM AND PROOF OF PAYMENT TO:
VOLUNTEER & EXEMPT FIREMAN'S BENEVOLENT ASSOCIATION
330 COLUMBUS AVENUE
VALHALLA, NY 10595