DANIEL H. COOK
ASSOCIATES INC

UNITED TEACHERS OF SEAFORD TRUST FUND
LOCAL 1780
Trust Additional Benefit (TAB)

MEMBER PLEASE PRINT

Member's Last Name	Member's First Name	Last 4 Digits of SSN
Full Mailing Address No. and Street	Apt. No.	Home Telephone #
City	State	Zip
I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other Group Plan except as indicated above.	Benefits are payable to Member only Member Sign here_____Date_____	

The TAB benefit program will reimburse a maximum of $700 ($400 for copay, $300 for vision).
Only expenses for members and spouses.

Please include copies of co-pay/prescription/deductible receipts and/or explanation of benefits denoting out of pocket expenses for dental, vision, medical co-pays and prescription drug co-pays. Please be advised that general health items such as vitamins, gym memberships, and most over-the-counter items are NOT ELIGIBILE. Reimbursements cannot be provided without complete receipts.

- **Members may submit claims for this benefit only ONCE per calendar year**

	Date	Expense	Amount
1.			
2.			
3.			
4.			
5.			

Mail completed form to:

UNITED TEACHERS OF SEAFORD TRUST FUND LOCAL 1780
C/O DANIEL H. COOK ASSOCIATES, INC.
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