Volunteer and Exempt Firemen's Benevolent Association of Uniondale, Nassau County, NY, Inc.
P.O. BOX 66, UNIONDALE, NEW YORK 11553
BUSINESS PHONE (516) 650-0899, Email: Uniondaleba@gmail.com
Organized 1942

Application for Aid for Unreimbursed Health & Wellness Expenses

Name: _____ Co. #_____ Date:

_____

Address:

_____

_____

Cell #: _____ Email:

_____

Unreimbursed Health and Wellness Expense Aid Options

Please indicate your reason for your request for reimbursement by putting a check mark in the appropriate box below and indicate the amount of the benefit being requested:
Total Amount Allowable is $600.00 per year.

- ☐ Prescription Eyeglasses or Contacts – Amount requested $_____
- ☐ Eye Exams – Amount requested $_____
- ☐ Hearing Aids – Amount requested $_____
- ☐ Physical Therapy or Chiropractic Therapy -– Amount requested $_____
- ☐ Eligible Medical, Dental, Prescription Drug or Hospital Services – Amount requested $_____
- ☐ Acupuncture– Amount requested $_____
- ☐ Mental Health or Psychiatric Therapy – Amount requested $_____
- ☐ Gym memberships – Amount requested $_____

☐ **TOTAL AMOUNT REQUESTED $ _____**

Documents Needed for Requests for Reimbursement Aid: The following documents are required to be submitted to the Association in order to process your request for financial aid:

- ☐ Supporting documentation for the Reimbursement Aid being requested (Receipts).

I certify that the information I have provided in this Application is true and correct to the best of my knowledge and belief. I understand that a false statement may disqualify me for benefits and/or for membership status in the Association. In addition, the Association shall have the right to recover any monies made to me because of a false statement, plus interest and its cost for collecting such monies (including attorney fees and collection costs).

Signature of Participant: _____ Date: _____

OFFICE USE ONLY			
Initials of Secretary:	Date:	☐ APPROVED	☐ REJECTED