Volunteer and Exempt Firemen's Benevolent Association
of Uniondale, Nassau County, New York, Inc.
P.O. BOX 66, UNIONDALE, NY 11553
BUSINESS PHONE (516) 477-4639
Email: uniondaleba@gmail.com • Website: www.uniondaleba.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 $250.00 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).

Signature

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