SOMERS FACULTY ASSOCIATION BENEFIT TRUST FUND

SECONDARY DENTAL & VISION BENEFIT PROGRAM CLAIM FORM

MEMBER'S NAME: ____

Members Address: ____

Number on Member ID Card (ID# or SSN): ______________________________ **Group #:** 3000

Maximum Benefit: $1,000 Family

- Services must be incurred between July 1, 2023 and June 30, 2024
- All claims for the fiscal year ending on June 30, 2024 must be received by The Preferred Group by September 30, 2024

Name of Member or Dependent	Service Category (Dental or Vision)	Date of Service	Amount not covered by any other plan

- Dental & Vision expenses must be incurred by you, your spouse, and/or eligible dependent children and not reimbursed by any other dental or vision plan.
- Claims will be processed and mailed in 2-3 weeks from receipt of submission. In the event you do not receive a check for a claim within this time frame please call (518-) 641-0321.

Please complete all sections of this form, attach the copies of the bills, explanation of benefits and circle the amount not covered by any other dental or vision plan.

______________________________ ______________________________

Signature Date

Claims can be submitted one of two ways:

Claim forms can be mailed to this address:	Claim forms can be scanned and emailed to:
SOMERS FACULTY ASSOC. TRUST FUND C/O The Preferred Group PO Box 15136 Albany, NY 12212 (518) 641-0321	Claims@tpgplans.com **When emailing "Somers Claims" must be included in the subject line.**