



SEE REVERSE SIDE FOR INSTRUCTIONS

PLEASE PRINT OR TYPE

NAME: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____ FILE NUMBER: _____

1. TITLE: _____ 2. SCHOOL/OFFICE: _____

3. SCHOOL/OFFICE ADDRESS: _____

4. DATE OF ACCIDENT: _____ 5. NATURE OF INJURY: _____

6. DESCRIPTION OF ACCIDENT: (If additional space is needed write on separate sheet and attach to claim)

7. WERE YOU ABSENT DUE TO INJURY? YES NO : If yes, see paragraph 1c of instructions.

8. CHECK HEALTH PLAN CURRENTLY ENROLLED IN AND CHOICE OF OPTIONAL BENEFITS RIDER:

HEALTH PLAN	NO OPTIONAL RIDER	OPTIONAL RIDER	UFT OPTIONAL RIDER
a. <input type="checkbox"/> HIP/HMO	<input type="checkbox"/>	<input type="checkbox"/>	
b. <input type="checkbox"/> MED-PLAN	<input type="checkbox"/>	<input type="checkbox"/>	
c. <input type="checkbox"/> GHI-CBP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. <input type="checkbox"/> GHI-TYPE C	<input type="checkbox"/>	<input type="checkbox"/>	

9. Are you or your spouse enrolled in any Private or Group Health Insurance Plans which provide coverage for any expenses incurred other than in section 8 above? YES NO If yes, please provide the following:

9a. Name of carrier _____
Carrier address _____
Policy holder _____ Policy number _____

9b. Name of carrier _____
Carrier address _____
Policy holder _____ Policy number _____

10. MEDICAL EXPENSES: \$ _____ (see § 12 of instructions) Subtract item 11 from item 10.

11. REIMBURSEMENTS: \$ _____ (see § 1e of instructions) Remainder is entered in item 12.

12. AMOUNT CLAIMED: \$ _____

13. I hereby submit a claim for medical expenses as a result of injuries sustained in the line-of-duty. The facts in connection with the injuries are indicated above. This claim is made by me and submitted to the Board of Education with the intent that the Board of Education rely thereon in approving and paying my claim.

SIGNATURE OF CLAIMANT

14. CERTIFICATE BY PRINCIPAL OR HEAD OF BUREAU

I hereby transmit herewith a claim submitted by _____ to the best of my knowledge, information and belief, the facts contained under paragraphs 1 through 7 are substantially true.

SIGNATURE AND TITLE

PRINT NAME

MAKE NO ENTRY BELOW THIS LINE (For Medical Bureau-Claims Unit use only)

Date Approved _____ For Claims Unit: _____

Amount \$ _____

Date Disapproved _____