**Body/Cardiac Scan Reimbursement Claim Form**

Employee Name: Active: Retired:

Address:

Phone #:

Payment is limited to a one time reimbursement of $75.00. This benefit is only for the **Active/Retired Correction Officer**.

Be sure your bills and receipts are copied and attached. **Do not send originals.** This completed form can be mailed to:

**Westchester C.O.B.A Welfare Fund**

**PO BOX 231**

**Thornwood, N.Y. 10594**

Type of Scan:

Date of Scan:

I certify that the above information is accurate and that the charges indicated were incurred by me. I have not received payment for the amount of this claim from any other insurer, benefit fund, IRC 125 plan or by any other means.

Members Signature Date