Orlando Police Benevolent Association Request for Benefits

1250 W. South St. Orlando, FL 32805, orlandopba@aol.com

Date Submitted: _____ Member:_____ EMP#: _____
First MI Last

DOB: ____/____/_____ Age: _____ Type of service: Medical: ☐ Dental: ☐ Optical: ☐

Describe service(s) rendered: _____

Physician: _____ Phone: _____ Check if Continuous Treatment: ☐
Date of **first** treatment regarding this request: ___/___/____
Date of **last** treatment regarding this request: ___/___/____ If Approved, mail check via?
Date of **final** insurance billing: ___/___/_____ Interoffice Mail:☐ US Mail: ☐
Were you **seen** / **admitted** to hospital? YES: ☐ NO: ☐

What is the total amount of **out-of-pocket** expenses as of the date of this request (The amount you have **PAID** and are asking to be reimbursed for **at this time**? $_____
Was insurance claim made related to this service? YES: ☐ NO: ☐
Was this service / treatment submitted to Medicare? YES: ☐ NO: ☐

Points of interest:

1. This request form, along with applicable **receipts**/invoices/etc, must be submitted **within sixty (60) days** of the date of the service(s) or final insurance billing.
2. Current deductible is $40 per course of continuous treatment.
3. The maximum benefit for dental and optical expenses is $400 per calendar year for each.
4. OPBA will only provide benefits for medical-related services that would normally be covered by the insurance plan **currently** offered to **active** members by the City for free.
5. The Association shall not be responsible for any bills incurred due to pregnancy cases, tubal ligation, vasectomies (or to reverse vasectomies), **prescriptions**, or any surgery/medication which is commonly recognized to be cosmetic in nature; Benefits will not be applicable towards services received related to Workman's Compensation.
6. A full explanation of coverage and limitations may be found in the OPBA By-Laws.

Member Mailing Address: _____
Phone: _____ E-mail: _____
How do you wish to be contacted for questions/concerns? E-mail: ☐ Phone: ☐ Letter: ☐

As a member in good standing with the OPBA, I hereby request benefits reimbursements to help offset my personal costs associated with the above-listed service(s). I have read the requirements and restrictions applicable to benefits requests. Further, I authorize those members of the OPBA responsible for the authorization and disbursement of benefits payments to discuss the specific treatments and/or services listed above with appropriate personnel within the City of Orlando's Benefits Section to aid in their determination of whether or not to grant benefits payments to me. I understand that any request(s) for benefits to which I am not entitled will constitute grounds for termination of my membership in OPBA.

MEMBER SIGNATURE: _____Rev. 06/21/17

For OPBA board use only	Treasurers	
Date Treasurer Received:	Received by:	YTD Benefits Received: $
OPBA Membership Confirmed : ☐	Confirmed By:	Paid with Check # : Check Mailed on date:
	Welfare Committee (WC)	
Date WC Received for review:	WC Received BY:	Welfare Committee Decision: ☐APPROVED ☐DISAPPROVED