Orlando Police Benevolent Association

100 S. Hughey Avenue, P.O. Box 913, Orlando, Florida 32802-0913

DATE: ____________________

TO: WELFARE COMMITTEE

RE: REQUEST REIMBURSEMENT FOR MEDICAL, DENTAL, OR OPTICAL EXPENSE

FROM: ___________________________________ EMP#___________
FIRST MI LAST

FOR OPBA USE ONLY
DATE REC'D: _______
REC'D BY: _______
ACTION BY WELFARE COMMITTEE: (circle one)
APPROVED
DISAPPROVED
CHECK #: _______

As a member in good standing with the Orlando Police Benevolent Association, I hereby request reimbursement for medical expenses. This claim is to be reviewed by the Welfare Committee for approval.

PLEASE CHECK ONE:

TYPE OF CLAIM: MEDICAL_______ DENTAL_______ OPTICAL_______

DESCRIBE SERVICES RENDERED:____

PHYSICIAN(S):_____________________________________ PHONE: ____________________________
DATE(S) OF TREATMENT:____
HOSPITAL(S):____

WAS INSURANCE CLAIM MADE FOR ABOVE EXPENSES? YES________ NO________

DOES MEMBER HAVE CO-INSURANCE (SPOUSE INSURANCE OR ANY OTHER INSURANCE)? YES/NO

IF YES, WAS CO-INSURANCE CLAIM MADE? YES______ NO______
IF YES, SUBMIT COPY OF CO-INSURANCE PAYMENT.

WHAT INSURANCE COVERAGE DO YOU HAVE THROUGH THE CITY (CIGNA, UNITED HEALTHCARE, PRU-CARE, GULF LIFE, OTHER)?__________________________ POLICY#_____________

NOTICE: This form must be submitted with all claims (medical bills or copies) for medical expense reimbursement from the Orlando PBA. All claims must be submitted **within sixty (60) days** from the date of the medical treatment or final insurance billing.

- Current deductible is **$40** per course of continuous treatment.
- The maximum coverage for dental expenses is **$400** within a calendar year.
- The maximum coverage for optical expenses is **$350** within a calendar year.
- There is no limit on medical claims that meet current City insurance guidelines AND have been submitted to and paid by the City insurance provider. Full explanation of coverage and limitations may be found in the OPBA By-Laws. **Denied claims may be appealed to the Board.**
- Claims cannot be honored for illnesses covered by Workman's Compensation, for cosmetic treatment, pregnancies, or birth control reasons and/or claims compensated for by insurance.

I have read the foregoing requirements and submit this request for payment of my medical, dental, or optical expenses as provided by the Orlando Police Benevolent Association.

SIGNED____ EMP #_____________