Superior Officers Council

City of New York Police Department
40 Peck Slip, New York, NY 10038

Captains Endowment Assn. **Lieutenants Benevolent Assn.**

HEARING AID BENEFIT APPLICATION

Instructions: Please complete the following information and return this application to the SOC Plan Office with a copy of a paid receipt for the purchase of the hearing aid(s).

1. Member Information

Last Name	First Name	SSN XXX-XX_-____	TAX ID
Address	City	State	Zip Code
Home Phone Cell Phone	Email	Gender ☐M ☐F	DOB

2. Patient Information

Last Name	First Name	Relationship to member -Select-	DOB

3. Hearing Aid Request

Right Ear: ☐	Left Ear: ☐	Both Ears: ☐

Date of Purchase: _____ (attach copy of paid receipt)
MM/DD/YYYY

4. For Office Use Only

Member Eligibility Verified: -Select-	Five Year Exclusion Period: Yes: ☐ No: ☐
Patient Eligibility Verified: -Select-	Claim Approved: Right Ear: ☐ Left Ear: ☐ Both Ears: ☐
Initial Benefit Claim: Yes: ☐ No: ☐	Total Paid: $_____ Date Paid: _____ MM/DD/YYYY
Date Last Claim Paid: _____ MM/DD/YYYY	Check No.: _____

PLEASE RETURN COMPLETED FORMS TO:

SUPERIOR OFFICERS COUNCIL
40 PECK SLIP
NEW YORK, NY 10038