

MASSACHUSETTS CORRECTION OFFICERS
HEALTH AND WELFARE FUND
PO Box 1300
MANCHESTER, NH 03105-1300
TEL: 800-346-4935
FAX: 603-647-4668
EMAIL: DLEBLANC@BENSTRAT.COM

MCOFU
REQUEST FOR REIMBURSEMENT

Name: _____ Social Security
#: _____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE CHECK IF NEW ADDRESS

REIMBURSABLE ITEMS:

Water Picks & Electric
Toothbrushes

Examples:
WaterPik *Oral-B* *Conair*
Braun *Sonicare* *Panasonic, etc.*

INSTRUCTIONS:

Please attach the original receipt for your water pick or electric toothbrush. You will be reimbursed \$25.00 or the cost of the purchase, if less. The maximum benefit available is \$25.00 per member per 24-month period. Must be eligible on dental plan prior to date of purchase.

EMPLOYEE SIGNATURE: _____

DATE: _____