

MASSACHUSETTS CORRECTION OFFICERS
HEALTH AND WELFARE FUND

PO Box 3938
MANCHESTER, NH 03105-3938
TEL: 800-346-4935
FAX: 603-647-4668
EMAIL: DLEBLANC@BENSTRAT.COM

REQUEST FOR
REIMBURSEMENT
(ONLY SUBMIT AFTER EFFECTIVE DATE
OF COVERAGE)

Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE CHECK IF NEW ADDRESS

REIMBURSABLE ITEMS:

Water Picks & Electric Toothbrushes

Examples:

*WaterPik
Braun*

*Oral-B
Sonicare*

*Conair
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.

EMPLOYEE SIGNATURE: _____

DATE: _____

MASSACHUSETTS CORRECTION OFFICERS
HEALTH AND WELFARE FUND

PO Box 3938
MANCHESTER, NH 03105-3938
TEL: 800-346-4935
FAX: 603-647-4668
EMAIL: DLEBLANC@BENSTRAT.COM

REQUEST FOR
REIMBURSEMENT
(ONLY SUBMIT AFTER EFFECTIVE DATE
OF COVERAGE)

Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE CHECK IF NEW ADDRESS

REIMBURSABLE ITEMS:

Water Picks & Electric Toothbrushes

Examples:

*WaterPik
Braun*

*Oral-B
Sonicare*

*Conair
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.

EMPLOYEE SIGNATURE:

DATE:
