COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY, INC.
Supplemental Workers' Compensation Disability

To submit a Supplemental Workers' Compensation Disability Claim you must:

1. Complete this form.
2. Attach the explanation of benefits statement from Workers' Comp for the benefit period being claimed.
3. Mail completed form and benefit statement to:

   Healthplex, Inc.
   Attn: Claims
   333 Earle Ovington Blvd., Suite 300
   Uniondale, NY 11553-3608
   Providers Call – (888) 468-2183 Press Option 1 for IVR or Option 3
   Members Call – (888) 468-5178 Press Option 1

This benefit will be effective after the member has been off payroll for 30 days and the Workers' Compensation benefit has been paid.

Member Information

Please Print

Member Name ______________________ Member Social Security No.______________________

Member Address____
Street

____
City State Zip Code

Date of Birth ______________ Sex ☐ Male ☐ Female

Check here if this is a new address ☐

Claim Data

I became disabled on :______________________

I am claiming supplemental benefits for the period from ______________ to ______________.

For the period of disability covered by this claim:

Are you receiving wages, salary or separation pay? ☐ Yes ☐ No

Are you receiving Workers' Compensation for work-connected disability? ☐ Yes ☐ No

I hereby claim Supplemental Workers' Compensation Benefits and certify that for the period covered by this claim I was disabled and that the foregoing statements, including accompanying documentation, are to the best of my knowledge true and complete.

Member's Signature ______________________________Date ______________