



## CLAIM FORM

NAME, ADDRESS and PHONE NUMBER OF  
CLAIMANT (PLEASE PRINT CLEARLY)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of claim: \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_  
or Federal ID#: \_\_\_\_\_

School District: \_\_\_\_\_

### Claimant (Employee or Contract Service Provider)

Directions: Please print legibly or type. Complete all items on this page. Provide information for your expenses.

*Claimant must complete this section if retired from a New York State pension system*

#### Retired From (Circle One):

NYSTRS NYSERS NYSPFS NYCTRS NYSBOE NYCERS NYCPPE NYCFDP NYSLRS

Retirement Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date	Description	Amount

\_\_\_\_\_  
Signature and Title of Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisor/Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Purchasing Official

\_\_\_\_\_  
Date

Budget Code (s) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1879 W. Genesee St. Rd. \* Auburn, New York 13021-9430 \* (315) 253-0361 \* FAX (315) 252-6493

\*If form is not filled out accurately it may be returned and will delay payment.\*