



## CLAIM FORM

NAME AND ADDRESS OF CLAIMANT  
(PLEASE PRINT CLEARLY)

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

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 NYCPPF NYCFDP

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

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

Date	Description	Amount
	<b>PBIS Claim form</b>	

Total \$ \_\_\_\_\_

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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