

**SUPREME COURT UNIFORMED OFFICERS
SECURITY BENEFIT FUND**

RETURN COMPLETED FORM TO:
Maloney Associates, Inc.
211 Broadway
Lynbrook, NY 11563

CLAIMANT'S STATEMENT

Claimant's Name	Age	Dependent's Name (If claim is for dependent)
Mailing Address		Relationship
City	State	Zip Code
		Sex
Soc. Sec. No.	Date of Birth	Mo Day Yr

SUPPLEMENTARY MATERNITY BENEFIT CLAIM

PLEASE ATTACH:

- A. A COPY OF THE HOSPITAL BILL
- B. A PHOTOCOPY OF YOUR CHILD'S BIRTH CERTIFICATE

I hereby certify that all statements made on this form and the attachments are correct.

Date _____ Signature _____

CERTIFICATION BY FUND OFFICE

Effective Date

Authorized Signature
