StirlingBenefits™
Evolving the Business of Benefits℠

Teachers' Retirement Board

CT. STATE TEACHERS' RETIREMENT BOARD

CLAIM FORM

Member Information

FULL NAME OF MEMBER: ______________________________

Patient Name

ADDRESS: ______________________________

Street City State Zip

ID NUMBER: ______________________________ Phone (_______)____________________

EMAIL ADDRESS: ______________________________

MEMBER SIGNATURE: ______________________________

Provider Information

Type of claim (please check):

- ☐ Vision
- ☐ Hearing
- ☐ Out of Country

Date of Service: ______________________________

Provider Name: ______________________________

Please mail this completed form along with a copy of your itemized bill to:

STIRLING BENEFITS, INC.
ATTN. TRB UNIT
20 ARMORY LANE
MILFORD, CT 06460-3347

If you prefer, you may also fax the claim to (203) 876-1465