EAST WILLISTON TEACHERS ASSOCIATION BENEFIT FUND

Benefit Fund

ACTIVE

MAIL COMPLETED FORM TO:

East Williston Teachers Association Benefit Fund
253 West 35th Street, 12th Floor
New York, New York 10001

HEARING AID CLAIM FORM

MEMBER'S LAST NAME	FIRST NAME INITIAL	SOCIAL SECURITY NO.
FULL MAILING ADDRESS NO. AND STREET	APT. NO.	HOME TELEPHONE NO.
CITY STATE ZIP CODE	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? ☐ YES ☐ NO	IS THIS THE FIRST HEARING AID CLAIM FILED BY YOU? ☐ YES ☐ NO
MEMBER'S BIRTH DATE MONTH DAY YEAR	MEMBER'S CURRENT SCHOOL	

IS THE ABOVE NAMED MEMBER IN THE EMPIRE PLAN? ☐ YES ☐ NO

IS THE ABOVE NAMED MEMBER COVERED BY ANY OTHER GROUP PLAN WHICH PROVIDES A HEARING AID BENEFIT?
☐ YES ☐ NO
IF YES, PLEASE INCLUDE AN EXPLANATION OF BENEFITS FROM YOUR PRIMARY INSURANCE COVERAGE. THIS BENEFIT IS SECONDARY TO YOUR PRIMARY COVERAGE.

I CERTIFY THAT THE INFORMATION GIVE IS CORRECT AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. BENEFITS ARE NOT AVAILABLE UNDER ANY OTHER GROUP PLAN EXCEPT AS INDICATED ABOVE.

Member Sign Here _____ Date _____

TO BE COMPLETED BY PHYSICIAN, OTOLOGIST OR AUDIOLOGIST

EXAMINATION: Patient's Name: _____

Hearing Loss: _____% Left Ear _____% Right Ear

Date of Exam: _____ Charge for Exam: $

MATERIALS:

Type and Model of Hearing Aid: _____

Cost of Hearing Aid: $_____

I am a legally qualified: ☐ Physician ☐ Otologist ☐ Audiologist

Signature _____ Date

Office Address City State Zip

Telephone Number _____ License Number

PLEASE ATTACH ALL ITEMIZED BILLS AND/OR EXPLANATION OF BENEFITS FROM THE PRIMARY INSURANCE CARRIER