BENEFIT CLAIM FORM

UNITED STAFF ASSOCIATION WELFARE FUND
253 West 35th Street, 12th Floor
New York, NY 10001
(914) 250-0700

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	SEX: M F	PATIENT BIRTHDATE: MO. DAY YEAR
PARTICIPANT'S (MEMBER) LAST NAME	FIRST NAME	MEMBER SOCIAL SECURITY # (LAST 4) XXX-XX-	
FULL MAILING ADDRESS		APT. NO.	EMPLOYEE SCHOOL BLDG
CITY	STATE	ZIP CODE	HOME TELEPHONE NO. (INCLUDING AREA CODE) ( )
EMPLOYER	WORK TELEPHONE NO. (INC. AREA CODE)	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? ☐ YES ☐ NO	IS THIS THE FIRST CLAIM FILED BY YOU YES ☐ NO ☐
IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO	IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER		
ARE BENEFITS AVAILABLE FROM ANY OTHER GROUP INSURANCE CARRIER FOR THE PATIENT? ☐ YES ☐ NO	IF "YES" GIVE NAME OF CARRIER, PLUS NAME AND I.D. NO. OF SUBSCRIBER IF YES, SPOUSE BIRTHDATE ____________MONTH ___________DAY		MEMBER'S BIRTHDATE ______MONTH _______DAY

I certify that the information given 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.

Benefits are payable to member only.

MEMBER SIGN HERE ____**DATE** _____________________

Use a separate form for each type of claim. Check appropriate box.

CLAIM MUST BE SUBMITTED WITHIN 180 DAYS AFTER SERVICES ARE RENDERED

☐ ***Optical Benefit* (Member only)**
This benefit provides up to $350.00 per calendar year.

☐ ***Optical Benefit* (Dependents)**
This benefit provides up to $250.00 per calendar year.

☐ ***Hearing Aid Benefit* (Member only)**
This benefit provides up to $200 per member once every 2 years. Once the initial $200 benefit is received, the Fund will pay an additional benefit of $10 to be used for the purchase of each additional hearing aid during the same 24 month period.

***ATTACH COPY OF PROVIDER'S BILL SHOWING SERVICE**