BENEFIT CLAIM FORM

UNITED STAFF ASSOCIATION WELFARE FUND

1040 Avenue of the Americas, 24th Floor
New York, NY 10018
(914) 250-0700

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT SELF ☐ SPOUSE ☐ CHILD ☐	SEX M F	PATIENT BIRTHDATE MO. DAY YEAR
PARTICIPANT'S (MEMBER) LAST NAME	FIRST INITIAL NAME		Member SSN (Last 4 #s) or Alternate ID
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?	IS THIS THE FIRST CLAIM FILED BY YOU?
IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO	IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE		
ARE BENEFITS AVAILABLE FROM ANY OTHER GROUP INSURANCE CARRIER FOR THIS 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 Date of Birth _____ 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 $450.00 per calendar year.

☐ ***Optical Benefit*** **(Dependents)**
This benefit provides up to $400.00 per calendar year.

****ATTACH THE FOLLOWING DOCUMENTATION TO THIS CLAIM FORM ****

- Original receipt, marked "paid", setting forth the services rendered, the provider of optical services and the patient receiving those services
- Copy of Vision Prescription from the optometrist, optician or ophthalmologist
- Separate claim forms for member and eligible dependents

In addition to requesting optical benefits, I hereby request payment for any eligible balance from the Variable Benefit. (Sign only if requesting Variable Benefit Payment for this claim).

MEMBER SIGN HERE _____ **DATE** _____