United Staff Association Welfare Fund
Variable Benefit Claim Form

RETURN THIS FORM TO
United Staff Association Welfare Fund
1040 Sixth Ave, 24th Floor
New York, NY 10001
(914) 250-0700

PATIENT'S NAME: (last name, first name)	RELATIONSHIP TO MEMBER	SEX (circle one)	PATIENT DATE OF BIRTH
	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	M F	MONTH DAY YEAR

MEMBER'S NAME (last name, first name)	MEMBER SOCIAL SECURITY #

HOME ADDRESS: Number and Street	APT.	HOME PHONE (include area code)

CITY	STATE	ZIP	PAYROLL TITLE	EMPLOYER PHONE (include area code)

I certify that the information given is correct and authorize release of any information necessary to process this claim.

MEMBER SIGN HERE _____ Date _____

Benefits are payable to member only

Effective, 01/01/2016, the Variable Benefit provides you with a supplemental payment of up to $600 maximum per family per plan year (January1 - December 31) to assist in certain out-of-pocket expenses.

This benefit can only be used to supplement those benefits listed below.

Submission of this benefit is allowed only when the amount is $25.00 or more.

This is a supplemental benefit and therefore items or procedures not covered under the primary plans are not covered by this benefit.

Please check the benefit below and include all bills, receipts, cancelled checks and **explanation of benefits** denoting your out-of-pocket expense.

Dental

☐ Charges in excess of the dental plan maximums ($3,000 annual dental maximum) for **member**
☐ Charges in excess of the dental plan fee schedule for covered expenses for **member**

☐ Charges in excess of the dental plan maximums ($3,000 annual dental maximum) for **covered dependents**
☐ Charges in excess of the dental plan fee schedule for covered expenses for **covered dependents**

Optical

☐ Vision Care expenses and services in excess of the $450 per **member** under the Fund

☐ Vision Care expenses and services in excess of the $300 per **covered dependents** under the Fund

The Variable Benefit will pay up to $600 maximum per family

1/1/2016