Marble Industry Supplemental Fund
1040 Avenue of the Americas, 24th Fl
New York, N.Y. 10018
(212) 505 – 5050
Email: Applications@dhcook.com

Application for Supplemental Benefit for Medical

All Medical claims **MUST be processed by Benefits before the claim is processed by The Supplemental Department** for possible reimbursement for any out of pocket medical expenses not reimbursed by Marble Insurance and Welfare Fund. This application must be accompanied by proper proof.

Member's Name: ____

Address: ____
Street Number / Street Name City State Zip

Social Security Number: ______-_______-_________ Tel/Cell Number: (______) ________-__________

Email: _______________________________________

If claim is for eligible dependent:

Name: ____________________________________ Age: _______ Relationship:________________

Reason for Claim:

____

____

____

Amount Requested: $ _______________________

Do you want your benefit check deposited directly into your Bank Account on record? ___ Yes ___ No

If yes, please enter the last four digits of your Bank Account: _____________

I have attached all required itemized bills, receipts and Explanation of Benefits (E.O.B.), where applicable, substantiating the above request.

I hereby authorize any hospital, physician, dentist, or any other qualified provider of covered services who has attended, examined or rendered services to me or an eligible dependent; or any business firm or other person that has had business dealings with me or an eligible dependent to disclose when requested to do so by the Board of Trustees or at their direction, any and all pertinent information in connection with this claim.

I swear that foregoing statements and enclosed documents, where applicable, are true and accurate to the best of my knowledge, knowing that the Board of Trustees will rely on same in consideration of this claim.

Member's Signature: __________________________________ Date ______/______/________

This application MUST be accompanied with proper proof.