

UNITED PROBATION OFFICERS ASSOCIATION WELFARE FUND AND RETIREMENT WELFARE FUND
 375 West Broadway, 4th Floor New York, NY 10012 (212) 226-1069

PATIENT'S NAME		RELATIONSHIP TO PARTICIPANT SELF SPOUSE CHILD OTHER				SEX M F		PATIENT BIRTHDATE MO. DAY YEAR		
PARTICIPANT'S (MEMBER'S) LAST ADDRESS		FIRST NAME		INITIAL		SOCIAL SECURITY NO.				
FULL MAILING ADDRESS		NO. AND STREET				APT. NO.		ACTIVE <input type="checkbox"/>		RETIRED <input type="checkbox"/>
CITY		STATE		ZIP CODE		HOME TELEPHONE NO. (INCLUDING AREA CODE) ()				
JOB TITLE		WORK TELEPHONE NO. (INCLUDING AREA CODE) ()		IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED		<input type="checkbox"/> YES <input type="checkbox"/> NO		IS THE FIRST CLAIM FILED BY YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO
IS YOUR SPOUSE EMPLOYED		IF "YES", GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER.								
<input type="checkbox"/> YES <input type="checkbox"/> NO										
ARE BENEFITS AVAILABLE FROM ANY OTHER GROUP INSURANCE CARRIER FOR THIS PATIENT?		IF "YES", GIVE NAME OF CARRIER, PLUS NAME AND I.D. NO. OF SUBSCRIBER.				MEMBER'S BIRTHDATE				
<input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES", SPOUSE'S BIRTHDATE _____ MONTH _____ DAY				_____ 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 _____		

NOTE: These are brief explanations of the benefits as described in the benefit booklet. Please refer to the booklet for complete rules, regulations, benefits and your obligations in applying for benefits. **Attach copies of the original receipts to this claim.**

Check the benefit (s) for which you are applying:

- PROSTHETIC APPLIANCE (Retiree and Spouse Only)**
The Fund provides reimbursement for the benefit deductible, plus out-of-pocket expenses not covered by your health insurance for eligible services up to a lifetime as shown in benefit booklet.
- HEARING SERVICES**
This benefit is provided every three calendar year periods. The maximum benefit for an examination and for a hearing aid as shown in benefit booklet.
- OPTICAL (Member and Dependents)**
This benefit provides benefits as shown in benefit booklet per person per year for an eye examination, prescription lenses, contact lenses and/or frames. **Attach a copy of provider's itemized statement showing services rendered.**
- ABORTION BENEFIT (Female Employee and Spouse of Male Employee)**
This benefit provides benefits as shown in benefit booklet for medical expenses not covered by your health plan.
- VASECTOMY BENEFIT (Male Employee and Spouse of Female Employee)**
This benefit provides benefits as shown in benefit booklet for medical expenses not covered by your health plan. * (see below)
- ANESTHESIA BENEFIT**
This benefit provides 80% of your out-of-pocket expenses, to a minimum per year, as shown in benefit booklet, for in-hospital anesthesia expenses not covered by your health plan. * (see below)
- IN-HOSPITAL INDEMNITY (Employee, Retiree and Spouse of Retiree)**
This benefit provides benefits as shown in benefit booklet per week for up to 10 weeks when hospitalized or confined to a skilled nursing facility for medical expenses not covered by your health plan. * (see below)
- PRIVATE DUTY NURSING (Retiree and Spouse)**
This benefit provides 80% of your out-of-pocket expenses up to a maximum per year as shown in benefit booklet for the first 72 hours of care for private duty nursing expenses not covered by your health plan. * (see below)
- AT-HOME NURSING BENEFIT (Retiree and Spouse)**
This benefit provides 80% of your out-of-pocket expenses up to a maximum as shown in benefit booklet for nursing care not covered by your health plan. * (see below)
- PODIATRY BENEFIT**
This benefit provides up to amount shown in benefit booklet per year for podiatry expenses not covered by your health plan. * (see below)
- EMERGENCY** - amount as shown in benefit booklet.
- HAIR PROSTHESIS** - amount shown in benefit booklet.
- REHABILITATION BENEFIT/RETIREEES only** – amount as shown in benefit booklet

ATTACH TO THIS CLAIM FORM COPIES OF THE EXPLANATION OR DENIAL OF BENEFITS SHOWING THAT YOU HAVE EXPENSES NOT REIMBURSED BY YOUR HEALTH INSURANCE AND, IF MARRIED, BY YOUR SPOUSE'S HEALTH INSURANCE.