UNITED PROBATION OFFICERS ASSOCIATION
WELFARE FUND & RETIREMENT WELFARE FUND

2510 Westchester Ave., Suite 207 • Bronx, NY 10461 • P: 212.226.1069 • F: 917.398.1640

Please return completed, signed, and dated form, and supporting documentation, via mail to the above address or upload to www.asonet.com. All questions should be directed to the Fund at the above number. Save a copy of form and documentation for your records.

MEDICAL CO-PAYS (Member, Retiree, and Eligible Dependents)

For complete details of the benefit, please refer to the Summary Plan Description that can be found on our website.

Patient's Full Name _____

Relationship to Member: Self ☐ Spouse ☐ Child ☐ Other _____

Gender: M ☐ F ☐ Other ☐

Patient's Birthday: ____/____/____

Participant's (Member) Name

First _____ Middle _____ Last _____

Participant's Social Security Number _____

Participant's Full Mailing Address

Number _____ Street Name, Apt. No _____ City/Town _____

State _____ Zip _____ Home phone with area code _____

Active ☐ Retiree ☐

Job Title _____

Work phone with area code _____

Member's Birthday: ____/____/____

Is your spouse employed

Yes ☐ No ☐

If "YES", give name and address of spouse's employer _____

Are benefits available from any other group insurance carrier for this patient?

No ☐ Yes ☐

If YES, give name of carrier, plus subscribers' name and I.D. number _____

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 Signature _____ Date _____

NOTE: Please refer to the Summary Plan Description booklet for complete rules, regulations, benefits, and your obligations in applying for benefits. Attach copies of the **original receipts** to this claim. Any claim for benefit payment must be submitted to the Fund Office or uploaded to www.asonet.com no later than **one year** from date service is rendered.

OFFICE USE ONLY

Claim # _____ Date _____

Denied ☐ Approved ☐ Amount paid _____

NOTES

MEDICAL CO-PAYS

Please return completed, signed, and dated form, and supporting documentation, via mail to United Probation Officers Association Welfare Fund 2510 Westchester Ave, Suite 207, Bronx, NY 10461 or upload to www.asonet.com.

NOTE: The Fund Office will not return your medical bills. cash register receipts will not be honored.

Date of Service	Description of Service	Patient Name	Physician Name	Cost
			TOTAL	$