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.

REHABILITATION BENEFIT (Member, Retiree, Spouse & 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		Gender	Patient's Birthday
_____	Self Spouse Child Other _____		M F Other	____ / ____ / ____

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

Yes   No   _____

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