



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.

PROSTHETIC APPLIANCE (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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Gender M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>		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 <input type="checkbox"/> Retiree <input type="checkbox"/>							
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 <input type="checkbox"/> No <input type="checkbox"/>		_____					
Are benefits available from any other group insurance carrier for this patient?		No <input type="checkbox"/> _____ Yes <input type="checkbox"/> 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 _____

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