BENEFIT CLAIM FORM

UNITED STAFF ASSOCIATION WELFARE FUND
253 West 35th Street, 12th Floor
New York, NY 10001
(914) 250-0700

PATIENT'S NAME	RELATIONSHIP TO PARTICIPANT SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	SEX M F	PATIENT BIRTHDATE MO. DAY YEAR

PARTICIPANT'S (MEMBER) LAST NAME	FIRST NAME	MEMBER SOCIAL SECURITY # (LAST 4) XXX-XX-

FULL MAILING ADDRESS	APT. NO.	EMPLOYEE SCHOOL BLDG

CITY	STATE	ZIP CODE	HOME TELEPHONE NO. (INCLUDING AREA CODE) (_____)

EMPLOYER	WORK TELEPHONE NO. (INC. AREA CODE)	IS THE ABOVE ADDRESS DIFFERENT FROM YOUR LAST CLAIM FILED? ☐ YES ☐ NO	IS THIS THE FIRST CLAIM FILED BY YOU ☐ YES ☐ NO

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO — IF "YES" GIVE NAME AND ADDRESS OF YOUR SPOUSE'S EMPLOYER

ARE BENEFITS AVAILABLE FROM ANY OTHER GROUP INSURANCE CARRIER FOR THE PATIENT? ☐ YES ☐ NO	IF "YES" GIVE NAME OF CARRIER, PLUS NAME AND I.D. NO. OF SUBSCRIBER IF YES, SPOUSE BIRTHDATE _____MONTH _____DAY	MEMBER'S BIRTHDATE _____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** _____

Use a separate form for each type of claim. Check appropriate box.

CLAIM MUST BE SUBMITTED WITHIN 180 DAYS AFTER SERVICES ARE RENDERED

☐ ***Optical Benefit*** **(Member only)**
This benefit provides up to $450.00 per calendar year.

☐ ***Optical Benefit*** **(Eligible dependents)**
This benefit provides up to $300.00 per calendar year.

****ATTACH THE FOLLOWING DOCUMENTATION TO THIS CLAIM FORM****

- Original receipt, marked "paid", setting forth the services rendered, the provider of optical services and the patient receiving those services
- Copy of Vision Prescription from the optometrist, optician or ophthalmologist
- Separate claim forms for member and eligible dependents

9/28/2017