OPTIONAL BENEFITS CLAIM FORM

MEMBERS NAME:_____ SSN:_____

ADDRESS:_____ PHONE:_____

_____

***** LIST IN CHRONOLOGICAL ORDER – OLDER DATES TO THE MOST RECENT DATES (MAX OF 2 YEARS)**
***** COPY OF BILL, PROOF OF PAYMENT (RECIEPT OR CANCELLED CHECK) MUST BE ATTACHED.**
BILL SHOULD SHOW PATIENTS NAMES AND DATE OF SERVICE.
***** FOR PRESCRIPTIONS, ATTACH PRESCRIPTION LABEL NOT CASH REGISTER RECIEPT.**
***** FAXES SHOULD HAVE A COVER LETTER WITH THE NUMBER OF PAGES.**

PATIENTS NAME & RELATIONSHIP BIRTH DATE OF CHILD OR SPOUSE	DATE OF SERVICE	PROVIDER OF SERVICE	TYPE OF SERVICE (i.E. DENTAL, MEDICAL VISION, RX , HEARING)	AMOUNT CLAIMING
			TOTAL FROM FRONT:	
			TOTAL FROM BACK:	
			TOTAL AMOUNT CLAIMED:	

DATE: _____

MEMBERS SIGNATURE:_____

ATTESTATION BY "OPT OUT" PARTICIPANTS

Under penalty of perjury, I declare and attest that I have opted out of the Fund's group health insurance coverage and elected optional benefits only because I am covered under another group health insurance policy. That other group health insurance remains in effect. Each of these requested reimbursements is for medical care (defined in Internal Revenue Code § 213(d), which is not an essential health care benefit that must be covered by my other group health insurance policy or for co-insurance, co-payments or deductibles under my other group health insurance policy.

_____

PARTICIPANT SIGNATURE

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PATIENTS NAME & RELATIONSHIP BIRTH DATE OF CHILD OR SPOUSE	DATE OF SERVICE	PROVIDER OF SERVICE	TYPE OF SERVICE (i.E. DENTAL, MEDICAL VISION, RX , HEARING)	AMOUNT CLAIMING
				TOTAL: