

ILWU-PMA WELFARE PLAN

HEARING AID CLAIM FORM

PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS BEFORE COMPLETING THIS FORM

PART I. EMPLOYEE STATEMENT:

1. Employee _____ Local _____ Reg.No. _____
(or Survivor) (Print)

2. Address _____
(Street) (City) (State) (Zip Code)

Telephone Number (_____) _____

3. Patient _____ Relationship to Employee _____

4. Is the patient's condition due to injury or illness arising out of employment? YES NO

If YES, has worker's compensation been claimed for hearing aid expenses? YES NO

Do you intend to file a worker's compensation claim in the future? YES NO

5. If claim is for dependent child, date of birth _____

If for any reason this hearing aid is not purchased or is returned and I receive a reimbursement or refund, or I am reimbursed by worker's compensation, I agree to reimburse the Welfare Plan for the amount of the reimbursement/refund, not to exceed the benefit paid to me.

Employee's Signature _____ Date _____
(or Survivor's)

PART II. PHYSICIAN'S STATEMENT: (MUST BE COMPLETED BY PHYSICIAN (M.D., D.O., or Au.D.))

The hearing loss of _____ was medically evaluated on _____, and
(Patient's Name) (Date)

the patient may be considered a candidate for a hearing aid(s) for the: left ear right ear

Physician: (Print) _____, M.D./D.O./Au.D.

Address _____
(Street) (City) (State) (Zip Code)

Physician (M.D. or D.O.)
Signature _____ Telephone _____

PART III. HEARING AID DISPENSER (DEALER):

Hearing instrument is required for the: left ear right ear.

Instrument(s) purchased on _____ by _____
(date) (Patient's Name)

Total charges \$ _____ **(Attach itemized bills.)**

Expiration date of trial period _____.

Please notify ILWU-PMA Benefit Plans if aid(s) is not purchased or is returned for a refund.

Dispenser _____
(Name) (Address)

Telephone Number (_____) _____ Tax ID Number _____

Authorized Signature _____

(over)