IATSE National Health & Welfare Fund
Hearing Aid/ Annual Physical Examination Claim Form

Participant information:		
Last Name	First Name	
Participant Social Security Number	Date of Birth (mm/dd/yyyy) ☐ check box if deceased	
Mailing Address Street	City	State Zip
Email Address	Phone #	

Patient Information:		
Last Name	First Name	Date of Birth (mm/dd/yyyy)
Relationship to Participant	☐ Self ☐ Spouse ☐ Child	
Submitting claim for: Check all that apply	☐ Out of Network Annual Physical Exam	☐ Hearing Aid
Are any other benefits for expenses incurred available through another insurance company?	☐ Yes If yes, include explanation of benefits (EOB) from other carrier.	☐ No

Covered Expenses:

- Out of Network Annual Physical Examination
  Participants and their eligible dependents, who are covered under one of the following active Plans: Plan A, Plan C1, Plan C2 or Triple S, are eligible for reimbursement of up to $300 per calendar year, toward their cost for an out of network annual physical examination.

- Hearing Aid
  Participants and their eligible dependents, who are covered under one of the following active Plans: Plan A, Plan C1, Plan C2, Triple S or the Retiree Health Benefit Plan, are eligible for reimbursement of up to $1500 in a 36 month period for a hearing aid and/or batteries or repairs.

Participant's Authorization:
By signing below, I hereby certify that the expenses claimed have not been reimbursed, and are not reimbursable, under any other health plan coverage. I certify that services were provided by a licensed provider as mandated by state law. I hereby authorize any insurance company, prepayment organization, hospital, physician or the Board of Trustees of the IATSE National Health and Welfare Fund or its designated agent to release all information with respect to myself or any of my eligible dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization, when duly executed, shall serve in the same capacity as the original. I certify that all the information I have provided in support of this claim is complete, true and correct and all charges for which I am requesting reimbursement were actually paid by me or my dependent, where applicable.

Participant Signature ___________________________________ Date_______________

WARNING: If any person makes a false or fraudulent statement in connection with a claim, including submitting false or fraudulent information or concealing a material fact, the Fund may take action to recover any amounts it paid (plus interest and costs) and take any other legal action as it deems appropriate. A false or fraudulent statement could also subject a person to taxes and penalties.

Claim Filing Instructions (please PRINT legibly):

1. Please read, complete and SIGN this form. *Only the participant can sign this claim form. You must complete a separate claim form for each dependent.
2. Attach to this form documentation to support your claim. For out of network annual physical examinations, you would need to submit your explanation of benefits from the insurance company. For hearing aid reimbursement, please submit an itemized bill and any explanation of benefits (EOB) from other insurance carriers that you may have.

Refer to the your Summary Plan Description (SPD) for eligibility and filing requirements. This can be found on our website, www.iatsenbf.org.

How to submit this form:

Mail to: ASO- SIDS
P. O. Box 9005
Lynbrook, NY 11563-9005

If you have any questions, please contact ASO-SIDS at 877-390-5845 or in New York at 516-396-5525

FAILURE TO SUBMIT REQUIRED DOCUMENTATION AND/OR SIGN CLAIM FORM WILL CAUSE AN UNNECESSARY DELAY IN THE PROCESSING OF YOUR CLAIM OR MAY CAUSE YOUR CLAIM TO BE REJECTED.

Please note that all claims for reimbursement must be received within 12 months of the date of service.