RETURN TO:
ADMINISTRATIVE SERVICES ONLY, INC.
Department 66-E
PO Box 9005
Lynbrook, NY 11563

(516) 396-5500 / (718) 204-7172

ASSISTANT DEPUTY WARDENS DEPUTY WARDENS ASSOCIATION

☐ ACTIVE ☐ RETIREE

NEW DEPENDENT BENEFITS CLAIM FORM

2015

PATIENT INFORMATION (REQUIRED ON CLAIMS FOR SPOUSES AND DEPENDENTS)

Patient Name:	Birthdate:	Social Security #: (last 4 digits) X X X - X X - _____	Relationship to Member: Spouse ☐ Child ☐

MEMBER/EMPLOYEE INFORMATION

Member's Name:			Birth Date:	Social Security #: (last 4 digits) X X X - X X - _____
Street Address:	City:	State:	Zip Code:	Home Phone #:
Email: (Non-DOC)				Cell Phone #:
Work Location:				Work Phone #:

SPOUSE INFORMATION

Spouse's Name (Print)	Birth Date	Social Security #: (last 4 digits) X X X - X X - _____	Is spouse covered by another Benefits Plan? YES ☐ NO ☐
Name, Address, Telephone # of Spouse's Employer		Name of Benefit Plan	
ARE ANY OTHER BENEFITS AVAILABLE FOR THIS PATIENT? YES ☐ NO ☐		**IS THIS AN HMO PLAN?** YES ☐ NO ☐	

PROVIDER INFORMATION

Provider's Name (Print)	License #	Telephone #	Taxpayer ID #
Street Address	City	State	Zip Code

WAS THE EXAMINATION REQUIRED BY: AN EMPLOYER AS A CONDITION OF EMPLOYMENT? ***Yes*** ☐ **No** ☐ BY A GOVERNMENT BODY? ***Yes*** ☐ **No** ☐

BENEFIT: The New Dependent Benefit is payable in all cases where a child is born to a Member. The Fund will reimburse $2000 for each child born to the Member. This benefit is not available to be assigned to any Hospital or Medical Care Provider.

HOW TO FILE A CLAIM: After the birth, the Member must complete all sections (Patient Information, Member Information, Spouse Information, Provider Information and Authorization to Release Information) of the **NEW DEPENDENT BENEFITS CLAIM FORM**.

The completed claim form, must be accompanied by a copy of:

(1) HOSPITAL BILL OR PHYSICIAN'S BILL INCLUDING THE PATIENT'S NAME AND DATES OF SERVICE;

(2) EXPLANATION OF BENEFITS STATEMENT FROM YOUR BASIC MEDICAL INSURANCE CARRIER; AND,

(3) BIRTH CERTIFICATE FOR YOUR NEWBORN CHILD.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR FUND FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

AUTHORIZATION TO RELEASE INFORMATION

I *hereby authorize any insurance company, prepayment organization, hospital, physician, or The Board of Trustees of the Assistant Deputy Wardens Deputy Wardens Association (ADWDWA) or its designated agent to release all information with respect to myself or any of my 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 the information submitted by me in support of this claim is true and correct.*
Authorization must be signed or payment will not be made.

Signed (Member) Signature on file is not acceptable

_____ *DATE* _____

FOR OFFICE USE ONLY

Check #: _____

VERIFICATION SIGNATURE: _____ DATE ____/____/____ Check Issued Date: ____/____/____