IATSE NATIONAL BENEFIT FUNDS

HEALTH • 401(K) • ANNUITY • VACATION • PENSION •

MAIL TO: SIDS
PO Box 9005
Lynbrook, NY 11563-9005
In New York.....(516) 396-5525
Outside New York.....(877) 390-5845

FAXES NOT ACCEPTABLE

PATIENT INFORMATION (REQUIRED ON ALL CLAIMS)

Patient' Name	Birth Date	Relationship to Member
	___/___/___	☐ Self ☐ Spouse ☐ Child

MEMBER INFORMATION

Member's Name		Birth Date	Social Security Number	
		___/___/___		
Address	**City**		**State**	**Zip Code**
Daytime Telephone No.	**Evening Telephone No.**			

HOW TO FILE A CLAIM

1. **PLEASE INDICATE THE BENEFITS FOR WHICH YOU ARE APPLYING AND ATTACH A DETAILED ITEMIZED STATEMENT FOR THE EXPENSE THAT YOU INCURRED AND ANY EXPLANATION OF BENEFIT VOUCHERS FROM OTHER INSURANCE COVERAGE'S THAT YOU MAY HAVE.**

   ☐ **ANNUAL PHYSICAL EXAMINATION REIMBURSEMENT-**FOR ACTIVE MEMBERS AND THEIR ELIGIBLE DEPENDENTS

   ☐ **HEARING AID-** FOR ACTIVE AND RETIRED MEMBERS AND THEIR ELIGIBLE DEPENDENTS

2. **ARE ANY OTHER BENEFITS FOR EXPENSES INCURRED AVAILABLE THROUGH ANOTHER BENEFIT PROGRAM? _____ YES _____ NO**

   IF YES, YOU MUST INCLUDE AN EXPLANATION OF BENEFITS VOUCHER FOR THOSE SERVICES COVERED BY OTHER PLANS.

3. **SIGN THE COMPLETED CLAIM FORM BELOW AND RETURN IT WITH ALL REQUIRED DOCUMENTATION TO SIDS AT THE ADDRESS ABOVE.**

FAILURE TO FILE REQUIRED DOCUMENTATION AND/OR SIGN EACH CLAIM FORM WILL CAUSE AN UNNECESSARY DELAY IN THE PROCESSING OF YOUR CLAIM.

MEMBER'S SIGNATURE Authorization must be signed or payment will not be made.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby certify that expenses claimed have not been reimbursed, and are not reimbursable under any other health plan coverage. 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 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 complete, true and correct and that all charges claimed was the amount billed. **Authorization must be signed or payment will not be made.**

Member's Signature_____ **Date** _____

WHAT EXPENSES ARE COVERED

O **ANNUAL PHYSICAL EXAMINATION**	• **Who is Eligible?** Active members and their eligible dependents. • **What will be Covered-** The Fund will pay a maximum allowance of $300 per calendar year for a complete annual physical.
O **HEARING AID**	• **Who is Eligible?** Active and Retired members and their eligible dependents. • **What will be Covered?** You will be reimbursed up to $1,500 in a 36 month period for a hearing aid, and/or batteries or repairs.

AN EXPENSE MUST MEET THE FOLLOWING REQUIREMENTS:

1. **It must be for one of the services indicated above.**
2. **It has not, or will not be reimbursed from any other source.**
3. **It must be provided by a licensed provider as mandated by state law.**
4. **The date of service must be on or after 1/1/2001.**

IF YOU HAVE ANY QUESTIONS REGARDING YOUR CLAIM

Please Contact SIDS regarding this program at:

In New York..... 1-(516) 396-5525

Outside New York.....1-(877) 390-5845

IATSE National Benefit Funds
417 Fifth Avenue 3rd Floor
New York, NY 10016