MAIL TO:
ASO, Inc.
PO Box 9005, Dept. 47M
Lynbrook, NY 11563-9005
516-396-5500 / 800-537-1238

CWA LOCAL 1181 SECURITY BENEFIT FUND
SUPPLEMENTAL WELFARE FUND BENEFIT
REIMBURSEMENT CLAIM FORM

CALENDAR YEAR MAXIMUM: $300 per family

COVERED EXPENSES INCLUDE:
(1) Medical, Hospital, Dental, Optical and Prescription Drug Deductibles, Co-Payments, and Co-Insurance under your group health plan;
(2) Prescription Drug Costs;
(3) Non-covered dental and optical expenses;
(4) Over-the-counter drugs and medicines purchased without a prescription, such as aspirin and allergy medicines. Such drugs and medicines **must be** for the treatment of illness or injury and not merely to advance general good health; and
(5) Menstrual care products.

MEMBER INFORMATION

MEMBER NAME	BIRTH DATE	☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED If you are divorced, it is your responsibility to notify the Fund Office/disenroll your ex-spouse from coverage immediately. Otherwise, you will be financially liable for any amounts paid in error and you may lose your coverage under the Fund.		
ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
MEMBER'S SOCIAL SECURITY NO. (Last 4 Digits) XXX-XX- ☐☐☐☐		TELEPHONE NUMBER: EMAIL ADDRESS:		

PATIENT NAME	EXPENSE TYPE	CHARGES INCURRED	REIMBURSEMENT FROM ALL OTHER PLANS	NET OUT-OF-POCKET EXPENSES
1				
2				
3				
4				
TOTAL				

PLEASE SEE REVERSE SIDE OF FORM FOR CLAIM FILING REQUIREMENTS.
FAILURE TO PROVIDE THE REQUIRED DOCUMENTATION MAY DELAY THE PROCESSING OF YOUR CLAIM

IMPORTANT NOTICE

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

MEMBER SIGNATURE REQUIRED REIMBURSEMENTS ARE PAYABLE TO MEMBER ONLY

I HEREBY CERTIFY THAT EXPENSES CLAIMED HAVE NOT BEEN REIMBURSED AND ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE AVAILABLE TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL, OR PROVIDER, 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. I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED IN SUPPORT OF THIS CLAIM IS COMPLETE, TRUE AND CORRECT AND THAT ALL CHARGES CLAIMED WAS THE AMOUNT BILLED.

SIGNATURE OF MEMBER _____ DATE _____