

# ILWU-PMA BENEFIT PLANS /

International Longshore & Warehouse Union –  
Pacific Maritime Association [www.benefitplans.org](http://www.benefitplans.org)

1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109

PHONE (415) 673-8500

FAX (415) 749-1400

---

ILWU-PMA Pension Plan  
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan

October 24, 2024

To: ILWU Longshore, Ship Clerk, Walking Boss/Foreman, and Watchmen Locals

From: Mario Perez, Director of Benefit Plans

**Subject: ILWU-PMA Welfare Plan – Updated Hearing Aid Claim Form – Audiologist Signature Allowance**

Attached is an updated Hearing Aid Claim form which now allows for the signature of an audiologist. The form has also been updated to advise that eligibility can be obtained by contacting the Coastwise Claims Office.

Attachment

cc: Area Welfare Directors

A copy of this memo can be downloaded at [www.benefitplans.org](http://www.benefitplans.org)

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)

## INSTRUCTIONS

- **A HEARING AID BENEFIT IS PAYABLE ONCE IN A THREE-YEAR PERIOD.** If the patient has previously obtained a hearing aid under this program, you may contact the Coastwise Claims Office to verify that the patient is currently eligible for a hearing aid benefit.
- For description of eligibility, benefits and limitations, refer to Hearing Aid Program Supplemental Summary Plan Description.
- Employee, examining physician, and dispenser of hearing aid must complete this form.
- For claims on or after December 1, 2023, mail completed form to:

ILWU-PMA Coastwise Claims Office  
P.O. Box 429101  
San Francisco, CA 94142

Phone (800) 955-7376  
FAX (415) 495-0511