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