ILWU-PMA WELFARE PLAN

1188 Franklin Street, Suite 101

San Francisco, CA 94109

HEARING AID CLAIM FORM FOR OREGON KAISER ELIGIBLES

HEARING AIDS MUST BE PURCHASED AT OREGON KAISER

EMPLOYEE STATEMENT:

1. Employee _____ Local _____ Reg.No._____
   (or Survivor) (Print)

2. Address_____
   (Street) (City) (State) (Zip Code)

3. Patient_____ Relationship to Employee_____

4. If claim is for dependent child, date of birth _____

If for any reason this hearing aid is returned and I receive a refund, I agree to reimburse the ILWU-PMA Welfare Plan for the amount of the refund, not to exceed the benefit paid to me.

Employee's Signature_____ Date_____
(or Survivor's)

Telephone Number (_____)_____

Optional

ASSIGNMENT OF BENEFITS:

I hereby assign benefits due me to the extent of expenses incurred and payable under provisions of the ILWU-PMA Welfare Plan Hearing Aid Benefit Program to:

Kaiser Foundation Health Plan of the Northwest

Date_____ Signed _____
(Patient)

BENEFIT PLAN USE ONLY:

Claim Incurred_____
(Date)

Kaiser Plan provided Hearing Aid for ☐ Left Ear ☐ Right Ear
($5 member copayment)

Second Hearing Aid required for ☐ Left Ear ☐ Right Ear

Computation: 90% of $_____up to maximum of $_____Amt. Payable_____

Examined_____Date_____Certified by_____Date_____

COPY TO CLAIMANT