MULTI-BENEFITS CLAIM FORM

FOR OFFICE USE ONLY	INV. CODE

Social Service Employees Union Local 371

WELFARE FUND

817 BROADWAY • NEW YORK, N.Y. 10003 - TEL: (212) 777-9000

DO NOT USE THIS FORM FOR ANY OTHER BENEFITS

CIRCLE ONE ONLY: S.A.T. COURSE HEARING AID ABORTION BENEFIT

PROSTHETIC APPLIANCE OPTICAL BENEFIT

DEPENDANT LAST NAME	DEPENDANT FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH

MEMBER LAST NAME	MEMBER FIRST NAME	SOCIAL SECURITY NO.	HOME PHONE

HOME ADDRESS					APT, NO.		MAIDEN NAME
NUMBER	*STREET*	CITY	STATE	ZIP			

PAYROLL TITLE	DEPARTMENT	WORK LOCATION	OFFICE PHONE

MEMBER'S SIGNATURE

ATTACH ALL BILLS: CASH REGISTER RECEIPTS AND CANCELLED CHECKS CANNOT BE PROCESSED.
ALL CLAIMS ARE SUBJECT TO AUDIT AND VERIFICATION.

TO BE COMPLETED BY PROVIDER OF SERVICES WITH STAMP IMPRINT AND SIGNATURE. (OR ATTACH BILLS OR RECEIPTS):

Date of Service: Dependant Name:

Describe Services Rendered:

Materials Provided:

NOTICE: SSEU LOCAL 371 MAKES PAYMENTS TO MEMBERS ONLY

PROVIDER STAMP:

PHONE

TAX (DENT. NO.

PROVIDER'S SIGNATURE	ELIGIBILITY CHK.