UNITED PROBATION OFFICERS ASSOCIATION
WELFARE FUND & RETIREMENT WELFARE FUND

2510 Westchester Ave., Suite 207 • Bronx, NY 10461 • P: 212.226.1069 • F: 917.398.1640

Please return completed, signed, and dated form, and supporting documentation, via mail to the above address or upload to www.asonet.com. All questions should be directed to the Fund at the above number. Save a copy of form and documentation for your records.

REHABILITATION BENEFIT (Member, Retiree, Spouse, & Eligible Dependents)

For complete details of the benefit, please refer to the Summary Plan Description that can be found on our website.

Patient's Full Name _____

Relationship to Member: Self ◯ Spouse ◯ Child ◯ Other ◯ _____

Gender: M ◯ F ◯ Other ◯

Patient's Birthday: ____/____/____

Participant's (Member) Name

First _____ Middle _____ Last _____

Participant's Social Security Number _____

Participant's Full Mailing Address

_____ Number

_____ Street Name, Apt. No

_____ City/Town

_____ State

_____ Zip

_____ Home phone with area code

Active ◯ Retiree ◯

Job Title _____

_____ Work phone with area code

Member's Birthday: ____/____/____

Is your spouse employed

Yes ◯ No ◯

If "YES", give name and address of spouse's employer _____

Are benefits available from any other group insurance carrier for this patient?

No ◯

Yes ◯

_____ If YES, give name of carrier, plus subscribers' name and I.D. number

I certify that the information given is correct and authorize release of any information necessary to process this claim. Benefits are not available under any other Group Plan except as indicated above.

Benefits are payable to member only.

_____ Member Signature

_____ Date

NOTE: Please refer to the Summary Plan Description booklet for complete rules, regulations, benefits, and your obligations in applying for benefits. Attach copies of the **original receipts** to this claim. Any claim for benefit payment must be submitted to the Fund Office or uploaded to www.asonet.com no later than **one year** from date service is rendered.

OFFICE USE ONLY

Claim # _____ Date _____

Denied ◯ Approved ◯ Amount paid _____

NOTES