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:

The hearing loss of _____ was medically evaluated on _____, and

the patient may be considered a candidate for a hearing aid(s) for the: left ear ☐ right ear ☐

Physician: (Print)_____, M.D./D.O.

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

Signature _____

PART III. HEARING AID DISPENSER (DEALER):

NOTE: This benefit is payable only to insured.

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 (_____)_____

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 Benefit Plans 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.
- Mail completed form to:

  ILWU-PMA Benefit Plans
  1188 Franklin Street – Suite 300
  San Francisco, CA 94109
  (415) 673-8500

Local 63

ILWU-PMA BENEFIT PLANS /

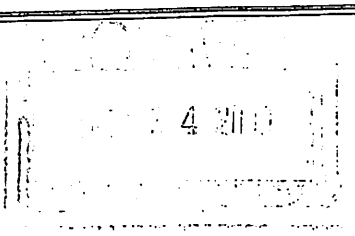
International Longshore & Warehouse Union —
Pacific Maritime Association

www.benefitplans.org

1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109 (415) 673-8500

ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan
ILWU-PMA Supplemental Welfare Benefit Plan



December 9, 2009

To: ILWU Longshore, Ship Clerk and Walking Boss/Foreman Locals and Watchmen Locals 26 and 75

From: Beth Sharpe, Manager, Welfare Plans

Subject: Hearing Aid Program

The Hearing Aid Program benefit was increased effective July 1, 2008, for claims incurred on or after that date, to 90% of the cost, up to a maximum of $3,000 per instrument ($6,000 for both ears).

The benefit includes the cost of the hearing aid, the cost of batteries and other ancillary equipment provided at the time the hearing aid is purchased, the doctor's hearing examination charges (if not otherwise covered), and the cost of services or repairs to the hearing aid.

In general, a Hearing Aid Program benefit is payable only once in a three-year period. Hearing Aid claims should be submitted to the Benefit Plans office for payment. Claim forms are available at the Locals and from the Benefit Plans office, or may be downloaded at www.benefitplans.org.

The enclosed insert for the Hearing Aid Program brochure includes a description of the benefit allowance and the names of the current Welfare Plan Trustees.

Enclosure

cc: Area Welfare Directors

ES:cy/opeiu29aflcio/MTP Hearing Aid Program-120909