ILWU-PMA WELFARE PLAN

Subsequent Prosthetic Device Benefit Claim Form

Employee must fill out Part 1.

Have your Physician fill out Part 2.

Have the Dispensing Supplier of the Subsequent Prosthetic Device fill out Part 3.

Note: Medicare Eligible must submit a copy of the Medicare Explanation of Benefits with this form.

PART 1 – EMPLOYEE STATEMENT

1. Name of Employee:	2. Local Number:	3. Registration Number:	4. Social Security Number:

5. Address (Street) (City) (State) (Zip Code)

6. Patient Name (if not employee):	7. Patient Date of Birth:	8. Patient's Relationship to Employee:
9. If married, is spouse employed? Yes ☐ No ☐	10. If Yes, spouse'sSocial Security Number:	11. Spouse's Employer:

12. Is patient covered by any Other Group Insurance or Health Service Plan? Yes ☐ No☐	13. If yes, Name and Address of Other Plan Administrator:
14. Do you have Medicare Insurance? Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐ Effective Date:	15. Does your spouse or any of your children have Medicare Insurance? Part A: Yes ☐ No ☐ Name: Part B: Yes ☐ No ☐ Effective Date:
16. Is patient's condition due to accident, injury, or illness arising out of the employment? Yes ☐ No ☐	17. If answer to #16 is yes, have you or the patient filed or do intend to file a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐
18. Is patient's condition due to accident, injury, or illness caused by some other party? Yes ☐ No ☐	19. If answer to #18 is yes, have you or the patient filed or do you intend to file any legal action or claim against the other party? Yes ☐ No ☐

20. **CERTIFICATION:** The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to the ILWU-PMA COASTWISE CLAIMS OFFICE as is required to properly pay all benefits, if any due me, my spouse or child for this claim:

Employee Signature: ______________________________ Date: ________________

(Employee or Authorized Person's Signature)

21. **ASSIGNMENT OF BENEFITS:** I hereby authorize the ILWU-PMA COASTWISE CLAIMS OFFICE to pay benefits directly to the dispensing provider or supplier of the Subsequent Prosthetic Device whose signature is shown in Part 3 of this form:

Employee Signature: ______________________________ Date: ________________

(Employee or Authorized Person's Signature)

ILWU-PMA WELFARE PLAN

Subsequent Prosthetic Device Benefit Claim Form

(Note: Medicare Eligible must submit a copy of the Medicare Explanation of Benefits with this form)

<table>
<tr><th colspan="6">PART 2 – PHYSICIAN'S STATEMENT</th></tr>
<tr><td colspan="3">1. Patient's Full Name:</td><td colspan="3">2. Diagnosis in connection with prosthetic device:</td></tr>
<tr><td colspan="3">3. Is patient's condition due to an accident:
Yes ☐ No ☐
Date:</td><td colspan="3">4. Is patient's condition due to accident, injury or illness arising out of employment?
Yes ☐ No ☐</td></tr>
<tr><td colspan="3">5. Is patient's condition due to an accident, injury or illness caused by some other party?
Yes ☐ No ☐
Date:</td><td colspan="3">6. Date patient was last seen for the condition in connection with prosthetic device:</td></tr>
<tr><td colspan="6">7. To your knowledge does patient have other Health Insurance or Health Service Plan Coverage?
Yes ☐ No ☐
If yes, please identify:</td></tr>
<tr><td colspan="5">8. Type of prosthetic device prescribed:</td><td>9. Date prescribed:</td></tr>
<tr><td colspan="6">10. Medical necessity for Subsequent Prosthetic Device. (State medical reason why existing prosthetic device needs replacement.):</td></tr>
<tr><td colspan="2">11. Attending Physician's Name and Address (please print):</td><td colspan="2">12. Federal Tax Number:</td><td colspan="2">13. Telephone Number:</td></tr>
<tr><td colspan="4">14. Physician's Signature (include degree or credentials):</td><td colspan="2">15. Date:</td></tr>
</table>

<table>
<tr><th colspan="6">PART 3 – DISPENSING SUPPLIER STATEMENT</th></tr>
<tr><td colspan="3">1. Patient's Name:</td><td>2. Date of Purchase:</td><td colspan="2">3. Total Charge:
$</td></tr>
<tr><td colspan="6">4. Description of prosthetic device purchased:
Standard Model ☐ Charge: $ ________________ Deluxe Model ☐(If Deluxe Model is purchased, please show cost of Standard Model in space at right.)
Description:</td></tr>
<tr><td colspan="2">5. Dispensing Supplier Name & Address (please print):</td><td colspan="2">6. Federal Tax Number:</td><td colspan="2">7. Telephone Number:</td></tr>
<tr><td colspan="4">8. Dispensing Supplier'sSignature(include degree or credentials):</td><td colspan="2">9. Date:</td></tr>
</table>

Please Return Completed Form to:

ILWU-PMA COASTWISE CLAIMS OFFICE
P.O. Box 429101
San Francisco, CA 94142