

PART (D): DEPENDENT CHILD INFORMATION

This part must be completed each time a claim is submitted for a dependent child age 19-23.

DEPENDENT

(print) Last Name

Init. First Name

Date of Birth

Social Security No.

Is the dependent employed? If yes, give name and address of dependent's employer:

Dependent's Employer

Address

Dependent is employed Full Time Part Time

My dependent child listed above is not married, is principally dependent upon me for maintenance and support, is under 23 years of age, and is my natural or adopted child.

Member's Signature

Date

PART (E): CLAIM FILING INSTRUCTIONS

Mail this CLAIM FORM promptly. Follow these instructions to avoid delay.

1. Member must complete Parts A and B of Claim Form.
2. Complete Part D if claim is for a dependent child age 19-23.
3. Have your physician or supplier complete Part C.
4. The completed Claim Form should be mailed to the Fund within 30 days of the date the services were provided.
5. A separate claim form must be completed for each patient.
6. If the Fund is not your primary insurer, you must attach a copy of the payment voucher from the other plan.

Mail your form to: **1199SEIU Benefit Funds
Times Square Station
PO Box 1007
New York, NY 10108-1007**