DOCTORS COUNCIL RETIREE WELFARE FUND

50 Broadway, 11th Floor, Suite 1101, New York, New York 10004 (212) 532-7690 Fax (212) 481-4137

☐ SELF-PAY COBRA

THIS COMPLETED FORM MUST BE POSTMARKED, IF MAILED, OR RECEIVED WITHIN ONE (1) YEAR FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED AND IF APPLICABLE, STATEMENTS FROM OTHER INSURANCE CARRIERS.

RETURN TO:
Doctors Council Retiree Welfare Fund
50 Broadway, 11th Floor, Suite 1101
New York, New York 10004
Phone: 212 532-7690 • Fax: 212 481-4137
Email: benefits@doctorscouncil.org

MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #

ADDRESS *Street* *City* *State* *Zip code*

HOME PHONE	HOME FAX	CELL PHONE	EMAIL

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	RELATIONSHIP TO MEMBER

IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? ☐ YES ☐ NO

NAME AND ADDRESS OF OTHER INSURER:

NAME AND ADDRESS OF OTHER INSURER:

NAME AND ADDRESS OF OTHER INSURER:

BENEFIT YOU ARE APPLYING FOR: (CHECK ONE BOX ONLY)

☐ BLOOD BENEFIT ☐ OPTICAL BENEFIT

☐ MAMMOGRAPHY BENEFIT ☐ MATERNITY/ADOPTION BENEFIT

MEMBER'S SIGNATURE DATE