EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365-3017 • (718) 591-1100 • FAX (718) 591-4200

ALL CLAIMS MUST BE SUBMITTED DIRECTLY TO: MAGNACARE
825 East Gate Blvd., DP-1001 - Garden City, NY 11530 - 1-800-548-0138
HEALTH BENEFIT REQUEST FORM

Participant Information (Please Print)

1. Name *(First Name, Middle Name, Last Name)*	**2. Soc. Sec. No.**	**3. Company Name**
4. Address *(Is this a new address? Yes No)*		**5. Phone #** ( ) -
6. Is spouse of participant covered by another medical benefits plan? Yes ☐ No ☐ If yes, name of other insurance carrier		

Patient Information (Please Print)

7. Name *(First Name, Middle Name, Last Name)*	**8. Soc. Sec. No.**	**9. Birth Date**	**10. Full-time Student?** Yes ☐ No ☐
11. Address *(If different from member)*		**12. Phone #** ( ) -	
13. Patient's Relationship to: Self ☐ Spouse ☐ Child ☐	**14. Patient's Sex:** Male ☐ Female ☐	**15. Was condition related to:** Patient's Employment ? Yes☐ No☐ An auto accident? Yes☐ No☐	

Sign below in order for this claim to be processed

16. I authorize the release of any information relating to this claim for the purpose of evaluating and administering benefits.

*Patient's (or Parent's Signature)*______________________________ *Date:*_______________

*Participant's Signature*______________________________ *Date:* _______________

Sign below in order for payment to be made directly to physician or Supplier of Service

17. I authorized payment of medical benefits to physician or supplier of medical services listed below.

*Patient's (or Parent's Signature)*______________________________ *Date:*_______________

Participant's Signature ______________________________ *Date:*_______________

Information From Physician or Supplier of Service (Please attach bills)

Name of referring physician	**If hospitalized, give dates:** **Admitted:** **Discharged:**
Name and address of facility where services rendered	**Diagnosis or nature of illness or injury**

Procedures, Medical Services, Supplies Furnished

Date of Service	Place of Service	C.P.T. Code	Description of Service	Charges

Name of Physician or Supplier	Taxpayer Identifying Number:
Address	

______________________________ ____________________ __________

Physician's or Supplier's Signature *Phone #* *Date*

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INSTRUCTIONS

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   Telephone - 1-800-548-0138

2. We will be unable to process your claim until all information and papers have been received.

   Submit **original itemized bills** only from each medical provider and facility. Copies are not acceptable**. (An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated, and the physician's or supplier's taxpayer identifying number).**

IMPORTANT

All Health Benefit claims must be filed no later than twelve (12) months after date of discharge from hospital or alcohol/drug rehabilitation facility or date of service, as applicable.

The recipient of benefits under this Fund, by applying for, and in fact accepting such benefits, agrees to reimburse the fund for all such benefits received, from the proceeds of any claim, settlement, judgment or other recovery from a third party, or his insurer, whose conduct caused the injuries which were the basis for the claim for benefits under this Fund.