PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING APPLICATION

Pension, Hospitalization and Benefit Plan

HOSPITALIZATION, SURGICAL AND MEDICAL BENEFITS OF THE JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY 158-11 Harry Van Arsdale Jr. Avenue • Flushing, New York 11365-3095 • 1-718-591-2000

	TO BE COMPLETE	D BY PARTICIPANT		
1. Participant's Name		2. Participant's PID #		
3. Participant's	Address	4. Home Phone #(Area Code)		
5. Current Emp	loyer	6. Date of Marriage_		
7. Patient's Nan	ne	8. Patient's Date of Birth	8. Patient's Date of Birth	
9. Patient Relat	ionship \Box Self \Box Spouse \Box Child	10. Full-Time Student? 🗌 Yes 🗌	10. Full-Time Student? Yes No	
11. Other Health	n Insurance? 🗌 Yes 🗌 No	12. Type of Plan \Box Group \Box Ir	12. Type of Plan Group Individual	
13. If yes, enter	insurance company, plan name, policy holder, policy number	er and effective date of coverage		
16. Is this patie17. Is the patier	B) An Accident Yes No If yes, give d bipant paying for or receiving continuation coverage (COBR nt under a Qualified Medical Child Support Order? Yes th covered by Medicare? Yes No cate effective date of coverage. Part A Part	s 🗌 No		
DATE OF SERVICE	PROVIDER'S NAME	SERVICES RENDERED	CHARGE	
SERVICE				
-	·			

Any intentional statement of incomplete, inaccurate and/or incorrect information may result in disciplinary action including the institution of a civil and/or criminal proceeding.

I have read the foregoing Notice and I certify to the completeness and accuracy of this application. I further certify that I have not submitted these bills for payment through the Pension, Hospitalization and Benefit Plan prior to this date.

Participant's Signature

Patient's Signature

PLEASE NOTE: APPLICATION CANNOT SERVE AS A BILL

INSTRUCTIONS

- 1. Fill in all information on application and sign where indicated. If you are a participant who is paying for or receiving continuation coverage (COBRA) under this Plan, indicate your name and your social security number in items 1 and 2 and omit item 5.
- 2. Attach your bill(s) to this form and mail to **MagnaCare** at the address below.
 - A. A separate claim form must be completed for each patient.
 - B. All bills must be itemized, include the provider's Tax ID number, diagnosis code(s) and procedure code(s).
 - C. When **Medicare** is the primary insurance, paper claims are required for the following services:
 - Covered services rendered by the Veteran's Administration;
 - The shingles (Zostavax) vaccination;
 - Hearing aid devices;
 - Diabetic needles and syringes;
 - Foreign travel claims; and
 - All coordination of benefit claims.

MAGNACARE INC. – JIB (LOCAL 3) P.O. BOX 1001 Garden City, NY 11530 1-877-624-6210 www.magnacare.com

Claims covered by Medicare for dates of service prior to August 1, 2011:

Applications must be mailed to the Pension, Hospitalization and Benefit Plan and submitted with **all pages** of the explanation of benefit payment voucher from Medicare. It is not necessary to submit copies of the corresponding bills.

The recipient of benefits under this Plan, by applying for, and in fact accepting such benefits, agrees to reimburse the Plan 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 Plan.

All claims must be filed within one year following the date of service. Any claim that is not submitted within a 12-month period will be denied as untimely.

H-43 (3/20)