UFA/UFOA Surgical Assistance Fund
9 METROTECH CENTER
BROOKLYN, N.Y. 11201-3857

MD-35-1 (11/97) 109-991518-190

APPLICATION FOR BENEFIT IN SURGICAL ASSISTANCE FUND

Date _____

Retired ( )

Widow ( ) Name _____Social Security No._____

Address: _____Telephone No: _____
Town State Zip Code

Rank: _____ Unit No. _____ Div. _____ Date Retired _____

Name of Patient _____Age of Patient _____ Years

Relationship to Member _____ If child, give Date of Birth _____

Name of Doctor _____

Office Address _____Zip _____

Name of Hospital _____

Address: _____Zip _____

Doctor Used: HIP _____ GHI _____ Private _____ Others _____

Date/Dates of Operation: _____

One of the following must accompany this claim:

An Official Medical Document, such as a Hospital Operation Report. MD-48, GHI bill, Anesthesia bill, a statement from the Doctor, etc., **that states** the **name** of the **patient**, diagnosis, **full nature of the procedure** and the **date** the procedure was performed. (Coded medical evidence cannot be used by this office)

NOTE: Receipt of claims will only be acknowledged when claimant encloses a stamped, self-addressed post card with claim.

ANESTHESIA AND/OR SERVICES OF ANESTHESIOLOGISTS ARE **NOT** COVERED BY THE FUND.
CLAIMS 1 YEAR OR OLDER WILL NOT BE CONSIDERED UNDER ANY CIRCUMSTANCES.
ONLY DEPENDENT CHILDREN **UNDER** 19 YEARS OF AGE (INCLUDING FULL TIME STUDENTS) ARE ELIGIBLE FOR BENEFITS.

X _____
(SIGNATURE OF MEMBER)

----------DO NOT FILL IN BELOW----------
(For S.A.F. Use Only)

Date of Entrance in Fund _____ Benefits Received since June 30 _____$ _____

Case No. _____ Date _____

Amount to be Paid by Fund _____ Basic Fee Rate _____

Amount Deducted from Basic Fee Rate _____Check No. _____