

UFA/UFOA SURGICAL ASSISTANCE FUND
 9 METROTECH CENTER
 BROOKLYN, N.Y. 11201-3857
 718 999-1252

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: _____

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 CIRCUMSTAN. 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 _____