

**DOCTORS COUNCIL WELFARE FUND****www.doctorscouncil.com**50 Broadway, 11<sup>th</sup> Floor, Suite 1101, New York, New York 10004 (212) 532-5995 Fax (212) 481-4137

PLEASE CHECK THE BOX WHICH INDICATES THE PLAN YOU ARE COVERED UNDER:

 DOCTORS COUNCIL WELFARE FUND  RETIREE WELFARE FUND  DOCTORS COUNCIL BENEFIT PLAN**OUT-OF-STATE LEGAL SERVICES CLAIM FORM**PLEASE COMPLETE THIS FORM AND SUBMIT IT POSTMARKED WITHIN **180 DAYS** FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED. DOCTORS COUNCIL BENEFIT PLAN MEMBERS MUST SUBMIT IT POSTMARKED WITHIN **ONE YEAR** FROM THE DATE OF SERVICE.**RETURN TO:**Doctors Council Welfare Fund  
50 Broadway, 11<sup>th</sup> Floor, Suite 1101  
New York, New York 10004  
PHONE: 212 532-5995 • FAX 212 481-4137**MEMBER INFORMATION**

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #
ADDRESS <i>Street</i>	<i>City</i>		<i>State</i>	<i>Zip code</i>
HOME PHONE	WORK PHONE	FAX #	EMAIL ADDRESS	WORK SITE

**BENEFIT YOU ARE APPLYING FOR:** OUT-OF-STATE LEGAL SERVICES**ATTORNEY INFORMATION : PROVIDER MUST COMPLETE THIS SECTION**

NAME	ADDRESS	TELEPHONE NUMBER
DATE(S) OF SERVICE	TYPE OF SERVICE:	
	<input type="checkbox"/> REAL ESTATE CLOSING	
	<input type="checkbox"/> WILL PREPARATION	
Attorney's Signature for Legal Services: _____ Date: _____ License #: _____		

MEMBER'S SIGNATURE

DATE

Office use only: Payment \$ \_\_\_\_\_ Approved By \_\_\_\_\_ Check Signed By \_\_\_\_\_