

DOCTORS COUNCIL WELFARE FUND**DOCTORS COUNCIL RETIREE WELFARE FUND**50 Broadway, 11th Floor, Suite 1101, New York, New York 10004 (212) 532-5995 Fax (212) 481-4137 CURRENTLY EMPLOYED RETIRED SELF-PAY COBRA

PLEASE COMPLETE THIS FORM AND SUBMIT IT POSTMARKED WITHIN **180 DAYS FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED. WHERE APPLICABLE, YOU MUST ALSO SUBMIT STATEMENTS FROM OTHER INSURANCE CARRIERS.**

RETURN TO:

**Doctors Council Welfare Fund
50 Broadway, 11th 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

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	RELATIONSHIP TO MEMBER
IS PATIENT A FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME AND ADDRESS OF OTHER INSURER:				
NAME AND ADDRESS OF OTHER INSURER:				
NAME AND ADDRESS OF OTHER INSURER:				

BENEFIT YOU ARE APPLYING FOR: (CHECK ONE BOX ONLY)

<input type="checkbox"/> BLOOD BENEFIT	<input type="checkbox"/> OPTICAL BENEFIT
<input type="checkbox"/> MAMMOGRAPHY BENEFIT	<input type="checkbox"/> MATERNITY/ADOPTION BENEFIT

MEMBER' S SIGNATURE	DATE
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Office use only: Payment \$ _____ Approved By _____ Check Signed By _____