

DOCTORS COUNCIL WELFARE FUND**www.doctorscouncil.com**50 Broadway, 11th 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, 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

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 _____