**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 *Street* | *City* | *State* | *Zip code* |
|---|---|---|---|
| | | | |

| 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? YES NO | IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? YES 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)

☐ BLOOD BENEFIT ☐ OPTICAL BENEFIT

☐ MAMMOGRAPHY BENEFIT ☐ MATERNITY/ADOPTION BENEFIT

| MEMBER' S SIGNATURE | DATE |
|---|---|
| | |

**Office use only: Payment $_____ Approved By_____ Check Signed By_____**