UFCWTRUST
Working For Your Benefit
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SHINGLES VACCINATIONS & HEARING AIDS
CLAIM STATEMENT – MEDICAL BENEFITS

PART I: TO BE COMPLETED BY THE EMPLOYEE ONLY

1. MEMBER'S NAME: _____ _____
(LAST) (FIRST) (MIDDLE) SSN OR ID#

2. NAME OF PATIENT: _____ _____
(LAST) (FIRST) (MIDDLE) DATE OF BIRTH

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER'S SIGNATURE: _____ DATE: _____

PART II: FOR REIMBURSEMENT, PLEASE INCLUDE THE FOLLOWING:

1. If submitting a claim for reimbursement of a Shingles Vaccination, please ensure that you have attached both a copy of the prescription label and a copy of the receipt showing the payment amount.
2. If submitting a claim for reimbursement for the purchase of a hearing aid, please include both a copy of the invoice and a copy of the receipt showing the payment amount.