MULTI –BENEFITS CLAIM FORM

FOR OFFICE USE ONLY	INV. CODE	**Social Service Employees Union Local 371** WELFARE FUND 1501 BROADWAY, SUITE 450 • NEW YORK , N.Y. 10036 (212)777-9000	

DO NOT USE THIS FORM FOR ANY OTHER BENEFITS

CIRCLE ONE ONLY: ☐ S.A.T COURSE ☐ ABORTION BENEFIT ☐ HEARING AID ☐ PROSTHETIC APPLIANCE ☐ OPTICAL BENEFIT

DEPENDENT LAST NAME	DEPENDENT FIRST NAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH

MEMBER LAST NAME	MEMBER FIRST NAME	SOCIAL SECURITY NO.	HOME PHONE

HOME ADDRESS NUMBER STREET CITY STATE ZIP	APT. NO.	MAIDEN NAME

PAYROLL TITLE	DEPARTMENT	WORK LOCATION	OFFICE PHONE

MEMBER SIGNATURE

ATTACH ALL BILLS: CASH REGISTER RECEIPTS AND CANCELLED CHECKS CANNOT BE PROCESSED.
ALL CLAIMS ARE SUBJECT TO AUDIT AND VERIFICATION.

TO BE COMPLETED BY PROVIDER OF SERVICES WITH STAMP IMPRINT AND SIGNATURE (OR ATTACH RECEIPTS)

Date of Service: Dependent Name:

Describe Services Rendered:

Materials Provided:

NOTICE: SSEU LOCAL 371 MAKES PAYMENTS TO MEMBERS ONLY

PROVIDER STAMP: PHONE	TAX ID. NO.

PROVIDER'S SIGNATURE	ELIGIBLITY CHECK