



HOUSE STAFF BENEFITS PLAN

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SUPPLEMENTAL MAJOR MEDICAL BENEFIT CLAIM FORM

Eligibility: HSBP employees including eligible dependents.

Maximum reimbursement allowed: This supplement will pay an additional 20% of the amount reimbursed in connection with benefits provided by your primary major medical carrier. This 20% supplement will be calculated based on the total reimbursements received under the base plan during the benefit year. The maximum supplement per person per benefit year is 20% of \$5,000 in reimbursements or \$1,000 per person per benefit year. In no way will the reimbursements be more than what was paid out of pocket.

Claim Submission Rules:

- Entire claim form must be completed in full by participant, patient or parent, if minor.
- A separate claim form must be submitted per patient.
- You must attach the Explanation of Benefits (EOB) received from your primary carrier.
- All claims must be submitted to our office at the above-mentioned address within one year of the date of service. Claims submitted after one year will be denied.

Please complete the following:

Participant's Name: _____
(Last Name) (First Name)

Social Security No.: _____ Hospital where employed: _____

Home Address: _____

(City) (State) (Zip code)

Contact phone number: _____ Type (home, mobile, etc.) _____

E-mail address: _____

Patient's Name: _____
(Last Name) (First Name)

Relationship to participant: _____

Number of Explanations of Benefits (EOB's) attached: _____

Patient's Signature or parent, if minor: _____ Date: _____