ILWU-PMA WELFARE PLAN

HEARING AID CLAIM FORM FOR OREGON KAISER ELIGIBLES

HEARING AIDS MUST BE PURCHASED AT OREGON KAISER

EMPLOYEE STATEMENT:

1. Employee_____ Local____ Reg.No._____
   (or Survivor) (Print)

2. Address._____
   (Street) (City) (State) (Zip Code)

3. Patient,_____ Relationship to Employee._____

4. If claim is for dependent child, date of birth _____

If for any reason this hearing aid is returned and I receive a refund, I agree to reimburse the ILWU-PMA Welfare Plan for the amount of the refund, not to exceed the benefit paid to me.

Employee's Signature._____ Date._____
(or Survivor's)

Telephone Number (___) _____

PLEASE ATTACH ITEMIZED BILL(S).

CLAIMS OFFICE USE ONLY:

Claim Incurred_____
(Date)

Kaiser Plan provided Hearing Aid for ☐ Left Ear ☐ Right Ear

Total cost of aids$_____

Kaiser OR provides $1,500.00 per ear (maximum of $3,000.00 for both ears)

Portion payable by CCO$_____

Computation: 90% of $._____ up to maximum of $._____ Amt. Payable._____

Examined by_____ Date_____

Certified by_____ Date._____

For claims on or after December 1, 2023, mail completed form to: ILWU-PMA Coastwise Claims Office P.O. Box 429101 San Francisco, CA 94142 Phone (800) 955-7376 FAX (415) 495-0511