

Security Benefit Fund
Of the
UNIFORMED FIREFIGHTERS ASSOCIATION
204 EAST 23rd STREET ♦ NEW YORK, N.Y. 10010
Telephone 212-683-4723

MATERNITY ANESTHESIA BENEFIT CLAIM
(See Instructions on Reverse Side Before Completing Form)

(PLEASE PRINT)

Name of Firefighter _____ Social Sec No. _____ Badge No. _____

Address _____ Unit & No. _____

Name of Hospital in which Anesthesia was administered _____ Address of Hospital _____

Date maternity Confinement began _____ Date patient discharged _____

Name and title of person administering maternity anesthesia _____

Date maternity anesthesia administered _____

Bill for administration of anesthesia attached check()
ATTACH-GHI (OR OTHER HEALTH COVERAGE) ANESTHESIA PAYMENT SLIP
Blue Cross statement of coverage or hospital bill for patient's maternity confinement check()

Date _____ Signature of Firefighter _____

For Fund Office Use Only

Claim No _____

1. Eligibility of Firefighter verified
 2. Benefits amount _____
- Comments _____

Paid by _____ Reviewed _____
Check _____ / _____ Approved for _____
No. Date Payment _____

INSTRUCTIONS

1. Use this form only if you are applying for a maternity anesthesia benefit in connection with childbirth for your wife or yourself (if female Firefighter).
2. Answer all questions on the top portion of the form. Be sure to attach the bill for administering the maternity anesthesia. Bill must give name of patient, show when anesthesia was administered, and must be signed by the person administering maternity anesthesia, or hospital.

File with GHI (or other health coverage) for anesthesia when you receive payment from them send us the portion showing what you received from them for the anesthesia.

In addition to the anesthesia bill, you must attach the statement from Blue Cross showing how much of the patient's hospital bill for maternity was covered by Blue Cross. If you are not covered by a Blue Cross contract, then you must attach the hospital bill for the patient's maternity confinement.

3. The complete form should be returned to the Fund Office. If the patient is eligible for maternity anesthesia benefits, a check will be mailed to you at your home.
4. Filing of this claim indicates a change in your dependents. You are advised to forward with this claim, a copy of the Certificate of Birth or Certificate of Live Birth (from the hospital).

CUT OFF DATE: One year from date of birth of child and Administration of Anesthesia.