Asbestos Workers Local Union No. 24 Medical Fund

7130 Columbia Gateway Drive, Suite A
Columbia, Maryland 21046
Phone: (410) 872-9500
Fax (410) 872-1275

ANNUAL PHYSICAL EXAMINATION

THE BENEFIT ALLOWANCE WILL BE PAID TO THE EMPLOYEE ONLY

1. Print Employee Name ______________________ 2. Soc. Sec. No. ______________________

3. Print Address ______________________

4. Print City ______________________

5. Print State ______________ Zip ______________ 6. Telephone Number ______________________

Benefit Maximum: $500 per calendar year

7. Authorization and Certification

I hereby authorize any insurance company, organization, employer, hospital or physician to release any and all information with respect to this claim which may be necessary to determine any amount payable. I certify that the above statements and information are correct.

Signed at ______________________ on ______________________ ______________________
City and State — Mo. Day Yr. — Signature of Employee

8. If you wish payment to go directly to the Doctor, carefully read and complete the following. Otherwise, furnish PAID RECEIPTS.

Assignment

I hereby authorize payment directly to the physician of any benefits otherwise payable to me for services as described below, but such payment shall not exceed the maximum allowable for such services. I fully understand that I am financially responsible for all charges not covered by this Plan.

______________________ ______________________
Mo. Day Yr. — Signature of Employee

9. A DATE OF SERVICE	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E DAYS CHARGES		F OR UNITS	G TOS	H LEAVE BLANK
		PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)						

10. SIGNATURE OF PHYSICIAN OR SUPPLIER	11. HAS BILL BEEN PAID? IF YES, PAID RECEITS MUST BE FURNISHED — YES ☐ ☐ NO	12. TOTAL CHARGE	13. AMOUNT PAID	14. BALANCE DUE
SIGNED DATE	15. YOUR SOCIAL SECURITY NO.	16. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE & TELPHONE NO.		
17. YOUR PATIENTS ACCOUNT NO.	18. YOUR EMPLOYER I.D. NO.			