THE NATIONAL ASBESTOS WORKERS MEDICAL FUND
ANNUAL PHYSICAL EXAMINATION

Telephone
800-386-3632
410-872-9500

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

THE BENEFIT ALLOWANCE WILL BE PAID TO THE EMPLOYEE ONLY

Print Employee
1. Name _____

Soc. Sec.
2. No. _____

Print
3. Address _____

Print
4. City _____

Print
5. State _____ Zip _____

Telephone
6. Number _____

Benefit Maximum: $600 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: PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E DAYS CHARGES		F OR UNITS	G TOS	H LEAVE BLANK

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