PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING APPLICATION

Pension, Hospitalization and Benefit Plan

HOSPITALIZATION, SURGICAL AND MEDICAL BENEFITS OF THE JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
158-11 Harry Van Arsdale Jr. Avenue ● Flushing, New York 11365-3095 ● 1-718-591-2000

TO BE COMPLETED BY PARTICIPANT

1. Participant's N	Jame	2. Participant's Soc. Sec. No	2. Participant's Soc. Sec. No	
3. Participant's Address		4. Home Phone #(Area Code)		
5. Current Emplo	oyer	6. Date of Marriage_		
7. Patient's Name	e	8. Patient's Date of Birth	8. Patient's Date of Birth	
9. Patient Relation	onship 🗆 Self 🔻 Spouse 🗀 Child	10. Full-Time Student? ☐ Yes ☐	10. Full-Time Student? ☐ Yes ☐ No	
11. Other Health	Insurance?	12. Type of Plan Group II	12. Type of Plan ☐ Group ☐ Individual	
13. If yes, enter in	nsurance company, plan name, policy holder, policy	number and effective date of coverage		
14. Is claim relat	, and the first term of the second se	□ No give date and description of accident		
15. Is the particip	pant paying for or receiving continuation coverage ((COBRA) under this Plan?		
16. Is this patien	t under a Qualified Medical Child Support Order?	☐ Yes ☐ No		
	covered by Medicare?	_ Part B		
DATE OF SERVICE	PROVIDER'S NAME	SERVICES RENDERED	CHARGE	
Any intentional s and/or criminal p		information may result in disciplinary action including the ins	titution of a civil	
	oregoing Notice and I certify to the completeness and ugh the Pension, Hospitalization and Benefit Plan pr	d accuracy of this application. I further certify that I have not rior to this date.	submitted these bills	
	Participant's Signature	Patient's Signature	Date	

INSTRUCTIONS

- 1. Fill in all information on application and sign where indicated. If you are a participant who is paying for or receiving continuation coverage (COBRA) under this Plan, indicate your name and your social security number in items 1 and 2 and omit item 5.
- 2. Attach your bill(s) to this form and mail to **MagnaCare** at the address below.
 - A. A separate claim form must be completed for each patient.
 - B. All bills must be itemized, include the provider's Tax ID number, diagnosis code(s) and procedure code(s).
 - C. When **Medicare** is the primary insurance, paper claims are required for the following services:
 - Covered services rendered by the Veteran's Administration;
 - The shingles (Zostavax) vaccination;
 - Hearing aid devices;
 - Diabetic needles and syringes;
 - · Foreign travel claims; and
 - All coordination of benefit claims.

MAGNACARE INC. – JIB (LOCAL 3)
P.O. BOX 1001
Garden City, NY 11530
1-877-624-6210
www.magnacare.com

Claims covered by Medicare for dates of service prior to August 1, 2011:

Applications must be mailed to the Pension, Hospitalization and Benefit Plan and submitted with **all pages** of the explanation of benefit payment voucher from Medicare. It is not necessary to submit copies of the corresponding bills.

The recipient of benefits under this Plan, by applying for, and in fact accepting such benefits, agrees to reimburse the Plan for all such benefits received, from the proceeds of any claim, settlement, judgment or other recovery from a third party, or his insurer, whose conduct caused the injuries which were the basis for the claim for benefits under this Plan.

All claims must be filed within one year following the date of service. Any claim that is not submitted within a 12-month period will be denied as untimely.

H-43 (2/12) (Over)