

PREVENTIVE CARE FORM

SHEET METAL WORKERS LOCAL #110

American Benefits Corporation
3150 Rt 60
Ona, WV 25545
Attn: Karen Childers - Claims

EMPLOYEE SECTION

NAME OF EMPLOYEE _____ SOCIAL SECURITY NO. _____

HOME ADDRESS _____ DATE OF BIRTH _____

EMPLOYED BY _____

Are group health insurance benefits payable from any other source for the expenses submitted? YES NO

If "YES," Name _____ Policy No. _____

Address _____

If claim is for **Dependent**, answer the following questions: NAME OF DEPENDENT _____

DEPENDENT'S SOCIAL SECURITY NO. _____ DATE OF BIRTH _____ SPOUSE CHILD



MEDICAL EXAMINER SECTION

NAME OF PATIENT _____

Below are the covered services of the Preventive Care Benefit. Please place a check mark to the left of the service performed.

- A "Mammogram," limited to one such examination during any consecutive two calendar year period.
- A "Pap Smear and Office Visit," limited to one such examination and office visit during a calendar year.
- A "Routine Physical Examination, including a Prostate Examination," limited to one such examination during a calendar year.
- "X-Ray Examinations or Laboratory Tests associated with a Physical Examination."
- Smoking Deterrent Patches.

AFTER COMPLETION OF THIS FORM, PLEASE ATTACH ITEMIZED BILLS AND MAIL TO THE HEALTH FUND AT THE ADDRESS SHOWN ABOVE.

DATE _____, 19____ SIGNED _____, Degree _____
(PLEASE PRINT, THEN SIGN ABOVE YOUR PRINTED NAME)

PHYSICIAN'S T.I.N. _____ ADDRESS _____
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)



EMPLOYEE'S ASSIGNMENT

I HEREBY ASSIGN BENEFITS TO THE PROVIDER.

DATE _____, 19____ SIGNED _____
(SIGNATURE OF EMPLOYEE)



INFORMATION

1. Maximum amount payable by the Welfare Fund - \$300 per calendar year per individual.
2. Hospitalization (bed patient) for a Physical Examination will not be covered.
3. **Must be routine. If a medical diagnosis is listed, claim will be considered as Major Medical and not payable at 100%.**