PENNSYLVANIA FACULTY HEALTH AND WELFARE FUND
P.O. Box 60430
Harrisburg, Pennsylvania 17106

PART-TIME FACULTY
Preventive Care Benefits Package Claim Form

This Form May be Used for Members or, if Eligible,
Spouses/Same-Sex Domestic Partners
Print Clearly or Type

Faculty Member's Name _____

Faculty Member's Date of Birth _____

Patient's Name _____

Patient's Date of Birth _____

Mailing Address _____

Faculty Member's Telephone Number _____

Append detailed receipts from providers:

Vision Examination $_____

Dental Expenses _____

I understand that benefits provided to Part-Time Faculty and their eligible spouses/same-sex domestic partners are to be paid only after all other group insurance plans have made payment. I certify that my spouse/same-sex domestic partner and I have not received or submitted for payment for any benefits for which I am applying for reimbursement that has not been disclosed to the Pennsylvania Faculty Health and Welfare Fund. In no case shall benefits be paid in excess of actual charges taken together with other payments for which I may qualify. I understand that reimbursement will be paid to me only after completing this claim form in full, attaching detailed provider receipts and signing below as indicated.

BY:_____ DATE:_____
Faculty Member's Signature

IMPORTANT INSTRUCTIONS: Append detailed receipts and copies of payments from any other group insurance plan for which your spouse/same-sex domestic partner and you qualify for reimbursement. It is your responsibility to obtain payment from all other group insurance plans before submitting benefit claims to the Pennsylvania Faculty Health and Welfare Fund for consideration. This Part-Time Preventive Care Benefit Package is a supplemental benefit plan and it should always be regarded as a third-payor plan. Mail this completed form and receipts to the address listed above.

Revised: January 2014