



LOCAL 273

RETURN COMPLETED STATEMENT TO

UFFA WELFARE FUND

P. O. BOX 994

NEW ROCHELLE, N. Y. 10802



LOCAL 273

Physical Examination Benefit

Nº 2619

Member's Statement (Print or Type)

NAME	Birth Date	Soc. Sec. No.
ADDRESS	Phone	Blue Cross or GHI No.
ZIP	Member's Signature	
DEPENDENTS NAME (If claim is on dependent)	RELATIONSHIP	AGE
If claim is for dependent child, is dependent 19 or older? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If dependent child is 19 or older, is dependent a full time college student and fully dependent upon you for support? <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME OF COLLEGE	STATE	DATE OF GRADUATION

SCOPE OF EXAMINATION:

(All tests must be completed to receive payment)

1. PRIVATE & CONFIDENTIAL REVIEW OF MEDICAL HISTORY
2. COMPREHENSIVE PHYSICAL EXAMINATION
3. CHEST X-RAY
4. ELECTROCARDIOGRAM
5. BLOOD TESTS (includes CBC, BUN, Cholesterol, Uric Acid)
6. URINE TESTS
7. CONSULTATION
8. WRITTEN REPORT (If Requested)

Doctor's Statement Verifying The Above Was Completed (Print or Type)

NAME	Date of Examination
ADDRESS	Phone No. Charge for Exam.
ZIP	\$
	Doctor's Signature

This claim will not be honored unless signed by both member and physician. Paid in full receipt(s) must be submitted with this claim for the member to receive payment, if not, payment will be sent directly to the doctor(s).