

DOCTORS COUNCIL WELFARE FUND50 Broadway, 11th Floor, Suite 1101, New York, New York 10004 (212) 532-7690 Fax (212) 481-4137 CURRENTLY EMPLOYED SELF-PAY COBRA

THIS COMPLETED FORM MUST BE POSTMARKED, IF MAILED, OR RECEIVED WITHIN ONE (1) YEAR FROM THE DATE OF SERVICE, ALONG WITH YOUR RECEIPT FOR SERVICE(S) RENDERED AND IF APPLICABLE, STATEMENTS FROM OTHER INSURANCE CARRIERS.

RETURN TO:

Doctors Council Welfare Fund**50 Broadway, 11th Floor, Suite 1101****New York, New York 10004****Phone: 212 532-7690 • Fax: 212 481-4137****Email: benefits@doctorscouncil.org****MEMBER INFORMATION**

LAST NAME		FIRST NAME		MI	BIRTHDATE	SOCIAL SECURITY #	
ADDRESS <i>Street</i>		City			State		Zip code
HOME PHONE	HOME FAX	WORK PHONE	WORK FAX	CELL PHONE	WORK SITE		
HOME EMAIL				WORK EMAIL			

PATIENT INFORMATION

LAST NAME		FIRST NAME		MI	BIRTHDATE	RELATIONSHIP TO MEMBER	
IS PATIENT COVERED BY ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO							
NAME AND ADDRESS OF OTHER INSURER:							
NAME AND ADDRESS OF OTHER INSURER:							
NAME AND ADDRESS OF OTHER INSURER:							

BENEFIT YOU ARE APPLYING FOR: (CHECK ONE BOX ONLY) BLOOD BENEFIT OPTICAL BENEFIT MAMMOGRAPHY BENEFIT MATERNITY/ADOPTION BENEFIT

MEMBER'S SIGNATURE

DATE