Mail to:
730 Harrison St. Suite 415
San Francisco, CA 94107

SUP WELFARE PLAN, INC.

Pensioner Annual Hospital Medical Benefit Reimbursement Form

Tel: (415) 778-5490
(800) 796-8003

PENSIONER STATEMENT: To be completed & signed by the Pensioner claiming benefits for self or spouse (Please print)

PENSIONER

Name (First) (Middle) (Last)	SS #	Birthdate

Home Address	Male ☐
	Female ☐

City	State	Zip	Home Telephone #

Single ☐ Widowed ☐ Married ☐ Divorced ☐	Spouse's Name	Spouse's SS#	Spouse's Birthdate or Death Date

SPOUSE

This claim is being made for expenses incured for an Eligible spouse

Spouse's Name (First) (Middle) (Last)	Patient's Relationship to Pensioner	Spouse's Birthdate

Male ☐ Female ☐ If your spouse has other coverage including Medicare, your claims should first be submitted for consideration to the carrier and any eligible expenses that you are responsible for should then be submitted to the SUP Welfare Plan.

Assignment	**Amount Requested**	**$**

I do ☐ **I do not** ☐ I authorize the SUP Welfare Plan to make payment directly to the doctor or provider of service (unless you authorize payment directly to the provider, payment will be made to you).

Certification and Authorization for Release of Information

Under penalties of perjury, I certify the above statements are correct and complete, I hereby authorize the SUP Welfare Plan, Inc. and its authorized representatives to receive all information from each provider of service including doctors, dentists, chiropractors, pharmacists, optometrists, hospitals, Health Maintenance Organizations, insurance companies or any other persons or organizations related to any claim I make, in order that such claims may be properly evaluated and processed. This autorization shall be valid until revoked in writing, and a copy of this authorization shall be effective as the original. Any revocation shall apply only to the securing of information from the date the revocation is received by the SUP Welfare Plan office.

Date	Pensioner's Signature	Spouse's Signature

ANNUAL MEDICAL AND HOSPITAL BENEFIT

The SUP Welfare Plan will reimburse an eligible Pensioner / Widow for covered expenses incurred for himself and his eligible Dependents for hospital, medical, surgical, dental, prescription drug or vision care treatment up to the maximum benefit for which the Pensioner is eligible for the 12-month period ending ending July 31 of each year. This includes reasonable charges for actual expenses by any Hospital or Facility. The Plan also reimburses monthly Medicare Part B and individual medical insurance premiums. The Medicare premium reimbursement is paid to you on your pension check.

In order to be reimbursed for eligible medical and dental expenses you must include proof of expense that identifies the name of the provider, the date of service, the nature of the service provided, the patient and your liability for your expense. If you have other insurance coverage, these expenses must first be submitted to that carrier for consideration.

On your first submission for reimbursement of medical insurance premium, you must provide verification from the insurance carrier or HMO that identifies the type of insurance, the covered individuals and the premiums that you must pay. Subsequent claims may be filed by providing proof of payment of those ongoing premiums. Should your premiums change, verfication from the insurance carrier or HMO must be submitted.

Payment is charged to the benefit year based upon the date of service, not the date received by the Plan Office or the date that the expense is paid.

Important - Pensioner's Social Security Number must be shown on all bills, forms corresponence

730 Harrison St. Suite 415
San Francisco, CA 94107

SUP WELFARE PLAN, INC.
Pensioner Annual Hospital Medical Benefit

Tel: (415) 778-5490
(800) 796-8003

APPEALS PROCEDURE

No Participant or other beneficiary will have any right or claim to benefits under the Plan or from the Plan, except as specified in the Trust Agreement. Any dispute as to eligibility, type, amount or duration of benefit under the Plan or any amendment or modification thereof will be resolved by the Board of Trustees under and pursant to the Plan and the Trust Agreement, and its decision of the dispute is final and binding upon all parties to the dispute. No action may be brought for benefits provided by the Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim therefor has been submitted and determined by the Board of Trustees.

Your claim for benefits under the Plan must be approved or denied by the Plan Office within 90 days of receipt of such claim. If determination of the claim cannot be made within that time period, you will be notified prior to the end of the original 90 days and the Plan may take up to an additional 90 days to make a decision on the claims.

If your claim for benefits is denied in whole or in part, the Plan Office will notify you of such in writing. The notice will explain in detail the reasons for denial with special reference to Plan provisions upon which the denial is based, a description of any information or material necessary to perfect the claim and why such is necessary and an explanation of the right to petition for review.

To file an appeal of a denied claim, you must file a request for review of the claim within 60 days of your receipt of the denial notice. Failure to file a request within the 60-day period will constitute a waiver of your right to appeal the denial or to take any other action within respect to it. An appeal must be in writing, should state in clear and concise terms the reason or reasons for disputing the denial, and should be accompanied by any pertinent documentary material not already furnished to the Plan.

You will be advised of the Trustee's decision in writing as soon as practical, but in no event later than 60 days after receipt of review by the Plan Office. Should there be special circumstances, the time may be extended for the processing of such request for review for a period not to exceed 120 days after receipt of a request for review. The decision on review is in writing and will include a specific reason for the decision with specific references to the pertinent provisions of the Plan on which the decision is based. The decision of the Board of Trustees, with respect to a request for reconsideration, will be final and binding upon all parties, including the claimant and any person claiming under the claimant. The provisions of this section will apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under the any plan adopted by the Trustees or against the Plan, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.