UFA/UFOA SURGICAL ASSISTANCE FUND
9 Metro Tech Center
Brooklyn, NY 11201-3857

MD-35 (12/05)

SURGICAL ASSISTANCE FUND BENEFIT APPLICATION

Date ________________

Active ☐ Rank _____________ **>>>>>>>> Dues Paid at What Unit** ______________________

Retired ☐ Rank _____________ Date Retired ______________ Unit ______________

Widow ☐

Your Name_________________________________ _______ _______ _______ _______
Social Security No. **Last four Digits Only**

Address ___________________________________ Telephone No. _________________________

_______________________________________/____________/_______________________
Town State Zip Code

Name of Patient _____________________________________ Age of Patient __________________

Relationship to Member ________________________ If Child, give Date of Birth ________________

Date of Operation ____________________________ Was this procedure Covered by FDNY Compensation __________

Type of Procedure ____

ONE of the following **MUST** accompany this claim:

- A signed statement from the Doctor on his/her stationery.
- A GHI or Medicare benefit form indicating the date and nature of the procedure.
- An operating report from a hospital.
- Coded medical evidence **cannot** be used by this office.
- IN ANY EVENT, **THE DOCUMENT MUST INCLUDE: (1)** THE NAME OF THE PATIENT, **(2)** THE DATE OF THE PROCEDURE, AND **(3)** THE NATURE OF THE PROCEDURE.

NOTE: Receipt of claim will only be acknowledged when claimant encloses a stamped, self addressed post card or envelope with the claim.

Anesthesia is not covered by the fund, but a benefit will be provided for the surgical procedure.
Claims **one year or older** will not be considered under any circumstances.
Only dependent children under 19 years of age (including full time students) are eligible for benefits.

X _____________________________
(Signature of Member)

Do not fill below

(For S.A.F. Use Only)

Case No **Amount to be paid by the Fund $**