SURGICAL ASSISTANCE FUND
BENEFIT APPLICATION

Date _____

Active Member ☐ Rank _____ **>>>>>Unit where dues paid** _____

Retired Member ☐ Rank _____ Date Retired _____ Unit _____

Widow ☐

_____
Email Address

Your Name_____ _____
Social Security No. **Last four Digits Only**

Your Address _____ Telephone _____

_____/_____/_____
Town State Zip Code

Name of Patient _____ Age of Patient _____

Relationship to Member _____ If Child, give Date of Birth _____

Date of Operation _____ (If active) Was this procedure as a result of a **LOD injury** (Yes___) (No ___)

NAME OF THE SURGICAL PROCEDURE _____

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

- A signed statement from the Doctor on his/her stationery.
- An insurance statement or Medicare benefit form indicating the **DATE & NAME** of the procedure.
- An operating report from a hospital.

THE DOCUMENT MUST INCLUDE: (1) THE NAME OF THE PATIENT and (2) THE DATE OF THE PROCEDURE

*Anesthesia **is not covered** by the plan, but a benefit will be provided for the surgical procedure.
*Oral surgery or any type of dental work are **NOT COVERED** by the plan.
*Hearing Aids and Eye Glasses are **NOT COVERED** by the plan.
*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.

File by Mail	**File by Email**	**Contact Information**
Fire Department **Surgical Assistance Desk** **9 Metrotech Center Room 5E-40K** **Brooklyn, NY 11201-5431**	**SurgicalAssistancePlan@gmail.com**	**Office (718) 999-1252** **Mobile (646) 733-7052**

X _____
(Signature of Member)

Do not fill below

(For S.A.F. Use Only)

Case No. _____ Amount to be paid by the Fund $_____