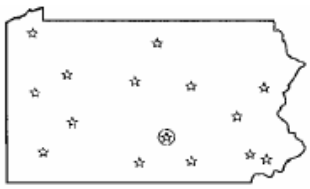

PENNSYLVANIA FACULTY

HEALTH AND WELFARE FUND

P.O. Box 60430
Harrisburg, Pennsylvania 17106-0430

Telephone: (717) 233-4776

PART-TIME FACULTY
Preventive Care Benefit Package Claim Form
Type or Print Clearly

Faculty Member: _____
Birth Date: _____
Social Security Number: _____

Spouses' Name: _____
Birth Date: _____
Social Security Number: _____

Mailing Address: _____
_____
_____

Reimbursement for: _____Member _____Spouse

Append Detailed Receipts From Providers

Vision Examination: $_____
Wellness Examination: _____
Mammography Examination: _____
Dental Expenses: _____
Total for All Receipts: $_____

I understand that benefits provided to Part-Time Faculty and their eligible spouses are to be paid only after all other group insurance plans have made payment. I certify that my spouse and I have not received or submitted for payment for any benefits for which I am applying for reimbursement that has not been disclosed to the Pennsylvania Faculty Health and Welfare Fund. In no case shall benefits be paid in excess of actual charges taken together with other payments for which I may qualify. I further understand that reimbursement will be paid to me by the Fund only after completing this claim form in full, attaching detailed receipts and signing below as indicated. I will also append copies of payments I receive from any other group insurance plan for which my spouse and I qualify for reimbursement. It is my responsibility to obtain payment from all other group insurance plans before submitting benefit claims to the Fund.

BY: _____ Date: _____
Signature of Faculty Member