HOSPITAL INCOME BENEFIT PLAN

NEW YORK STATE SUPREME COURT OFFICERS ASSOCIATION

SECURITY BENEFIT FUND

RETURN COMPLETED FORM TO:
MALONEY ASSOCIATES, INC.
211 Broadway
Lynbrook, NY 11563

INSTRUCTIONS FOR SUBMITTING CLAIM

1. Complete Part A. Answer all questions fully; incomplete answers may delay payment of benefits.
2. Have Part B completed by the hospital or by the attending physician at time of discharge.

PART A — MEMBER'S STATEMENT (Please Print)

Name of Member Mr. Mrs. Miss	**Social Security Number**
Address	**Date of Birth** Month Day Year

Is disability due to any occupational cause?

Did confinement occur while this person was on active duty in any Military, Naval or Air Force of any Country? ☐ Yes ☐ No

Name of hospital where confined City State

Name of attending physician Address Date of First Treatment

Nature of sickness or injury
(If injury, give date of accident)

I hereby certify that the above statements are correct

Date _____, 200____ Member's Signature _____

To all physicians, hospitals, clinics, dispensaries, sanitoriums, druggists, and all other agencies (including insurance companies, Blue Cross – Blue Shield). You are authorized to permit N.Y. State Supreme Court Officers Association Security Benefit Fund or its representatives to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions and medical expenses.

Of _____

Such information may be used to the extent deemed necessary by THE FUND to determine the validity or amount payable on account of this claim.

Date _____, 200____ _____
Member's Signature (Insured)

PART B — CERTIFICATION OF CONFINEMENT

Check One: Completed by ☐ Hospital ☐ Attending Physician

Name of patient	Age	Date Admitted	Still Confined? ☐ Yes ☐ No	Date Discharged

Diagnosis from records

Dates of any previous confinement From To	Is condition due to any occupational cause? ☐ Yes ☐ No

Completed by Taken from records on

Name_____ Title_____ _____, 200____

Address_____ Signature_____

PART C — To be completed by fund

Effective Date	Termination Date	Authorized Signature	Date