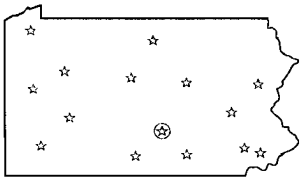

# PENNSYLVANIA FACULTY

HEALTH AND WELFARE FUND

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

Telephone: (717) 233-4776
Fax: (717) 233-4713

## WELLNESS EXAMINATION PLAN

**Both Sides of This Form Must Be Completed in Order to Qualify For This Benefit**

1. Member's Name: _____
2. SS #: _____
3. Home Address: _____

   _____
4. University: _____
5. Patient's Name: _____
6. Birthdate: _____
7. Patient's Relationship to Member: _____ Spouse

   _____ Member
8. Member's Signature: _____ Date: _____
9. Benefits may not be assigned to your doctor. Payment for services will be made to you by the Fund. This completed claim form must be submitted within three months after the date on which the physical examination was performed.
10. Submit to: Wellness Examination Plan
    Pennsylvania Faculty Health & Welfare Fund
    P.O. Box 60430
    Harrisburg, Pennsylvania 17106-0430

**–SIDE A–**

*To be Completed By Member*

REV. 3/00

# PHYSICIAN COMPLETE THE FOLLOWING

**Please Print or Type**

11. Physician's Name: _____

12. Office Address: _____

_____

13. Office Telephone Number: _____

14. Physician's I.D. No.: _____

15. This benefit supplements the patient's health care plan. Please attach a detailed bill.

16. The patient is responsible for the payment of medical services performed by you. Payment of this benefit may not be assigned to you by the member or patient (if different than member).

17. Amount charged by the physician for examination of patient listed on the reverse side of this claim form: $ _____

18. Physician's Signature: _____ Date: _____

**–SIDE B–**