CIVIL SERVICE BAR ASSOCIATION SECURITY BENEFITS FUND

c/o

Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

P.O. Box 5454, White Plains, NY 10602-5454 ● 866-647-4617

CLAIM FORM

INSTRUCTIONS: Complete all information on form
Enclose all itemized bills

1. PARTICIPANT'S SOCIAL SECURITY NO. | 2. FULL NAME OF PARTICIPANT FIRST, MIDDLE, LAST | 3. DATE OF BIRTH MONTH DAY YEAR | 4. SEX ❑ MALE ❑ FEMALE

5. ADDRESS (NO. & STREET) | APT. NO. | STATE | ZIP CODE | 6. HOME TELEPHONE NUMBER ( ) _____

7. EMPLOYER'S NAME AND ADDRESS | 8. OFFICE TELEPHONE NUMBER

CITY | STATE | ZIP CODE | ( ) _____

9. PATIENT'S NAME, IF OTHER THAN PARTICIPANT (FIRST, MIDDLE, LAST) | 10. DATE OF BIRTH OF PATIENT MONTH DAY YEAR

11. PATIENT'S RELATIONSHIP TO INSURED
❑ SELF ❑ SPOUSE ❑ CHILD ❑ REGISTERED DOMESTIC PARTNER

12. SEX ❑ MALE ❑ FEMALE

☐ OPTICAL BENEFIT

☐ LIFESTYLE BENEFIT

☐ NEW CHILD BENEFIT
A BIRTH OR ADOPTION CERTIFICATE MUST BE ATTACHED
➢ SOCIAL SECURITY # OF BABY _____

☐ HEARING AID BENEFIT

I certify that the forgoing information is true and correct _____
Participant's Signature Date

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.