

THIS SECTION IS TO BE COMPLETED BY THE EMPLOYEE — HEARING AID BENEFITS

Name of Employee _____ Date of Birth _____ S.S. No. _____

Home Address _____ Telephone No. _____

Employer's Name _____ Date Last Worked _____

Spouse's Name _____

If Spouse is Employed: Employer's Name _____

Employer's Address _____

Employee's Signature _____ Date _____

THIS SECTION IS TO BE COMPLETED BY THE ATTENDING PROVIDER

Name of Patient _____ Date of Birth _____

Patient's Address _____

Patient's Relationship to Employee _____
Self Spouse Child Other

Date of Service _____ Diagnosis _____

PLEASE ITEMIZE YOUR CHARGES BELOW:

Date Service Was Rendered	Type of Service Rendered	Total Charge
_____	Exam: _____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Type or Print Provider's Name _____

Address of Provider _____ Phone _____

Social Security or Federal ID No. for Provider _____

Physician's Signature _____ Date _____

EMPLOYEE MUST SIGN BELOW IF PAYMENT IS TO BE MADE DIRECTLY TO ABOVE PROVIDER:

Employee's Signature