BOSTON TEACHERS UNION
HEALTH AND WELFARE FUND

180 Mount Vernon Street
Boston, MA 02125

HEARING AID BENEFIT

IMPORTANT: Please read and follow the instructions on this form

If a Covered Teacher or Eligible dependent requires a hearing aid, the charge for the hearing aid up to a maximum of $5,000 ($2,500 per ear) will be paid for by the Fund directly to the supplier provided the following requirements are met:

1. The eligible person has undergone an Audiology Test, which has been authorized by a licensed physician, conducted at an appropriate hospital/facility; and the audiology report(s) and graph(s) are accompanied with the benefit request.

2. The invoice issued for the hearing aid is by the Audiology Department of an appropriate hospital/facility or by a supplier recommended by the Audiology Department; and that the invoice accompanies the benefit request.

Please note that this benefit does not include payment for any portion of the charge made by the hospital or facility for the Audiology Test. The hearing aid benefit will cover the cost of the hearing aid itself - no hearing aid accessories, additional fees, etc.

A HEARING AID BENEFIT WILL NOT BE PAID FOR HEARING AIDS NOT FOLLOWING THE ABOVE MENTIONED TERMS, NOR FOR A HEARING AID OF THE SAME PRESCRIPTION AS ONE PREVIOUSLY PAID FOR BY THE FUND FOR THE SAME PATIENT AND THE SAME EAR WITHIN A FIVE YEAR PERIOD

NOTE: This benefit does not pay for repairs nor does it pay for replacement of a lost or damaged hearing aid; therefore recipients may want to insure their hearing aid(s) against loss or damage.

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HEARING AID BENEFIT CLAIM FORM

TO BE COMPLETED BY COVERED TEACHER:

Covered Teacher's Name: _____ City ID# _____

Covered Teacher's Address: _____

Patient's Name: _____ Relationship to Teacher: _____ DOB: _____

I am covered by Health Benefits through (please circle one):

1. Blue Cross/Blue Shield
2. HMO Blue Cross/Blue Shield
3. Harvard Pilgrim Health Plan
4. Tufts Affiliated Health Plan
5. Neighborhood health Plan
6. Other: _____

Signature of Covered Teacher: _____

TO BE COMPLETED BY HOSPITAL OR FACILITY:

Date of Audiology Test: _____

Patient's Name: _____

Name of Physician Recommending Audiology Test: _____

Hospital/Facility Name: _____

Address: _____

Hearing aid(s) recommended for (please circle & include report with form): {Right Ear} {Left Ear} {Both Ears}

Recommended Supplier: _____

Authorized Signature: _____

TO BE COMPLETED BY SUPPLIER:

Name of Supplier: _____

Address: _____

Cost of Hearing Aid **(Attach Invoice)**: $_____ Date: _____

INSTRUCTIONS: Make sure the form is complete and accurate. Return the completed form with a copy of the Audiology Report, Graph and Invoice to the Boston Teachers Union, at the address shown on the top of this page. You may call us at (617)288-0500 to confirm that the teacher is still eligible for this coverage in the amount of the purchase price.

*****THE FUND MAKES PAYMENT DIRECTLY TO THE SUPPLIER*****

TEACHER FUND OFFICE USE ONLY:

Check#: _____ Date Issued: _____ Amount Paid: _____ Approved By: _____

THIS BENEFIT DOES NOT PAY FOR REPAIRS OR REPLACEMENT OF LOST OR DAMAGED HEARING AID(S); THEREFORE RECIPIENTS MAY WANT TO INSURE THEIR HEARING AID(S) AGAINST LOSS OR DAMAGE