BAC Local Union 15 Welfare Fund

PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2668
Toll Free: 1-833-479-9428

Annual Physical Lower Deductible Benefit Form

Member and Physician must complete this form in full.

CLAIMANT'S STATEMENT (MEMBER)

Name: _____ SS#: _____

Address: _____

Date: _____ Signed: _____

ATTENDING PHYSICIAN STATEMENT

Patient's Name: _____

The above patient received a COMPLETE ANNUAL ROUTINE PHYSICAL EXAMINATION in my office on: _____

(Date)

Date: _____ Signed: _____

Name (printed): _____

Address: _____

Phone: _____

**This form is due to the Fund Office no later than December 15th of the current year to receive the lower deductible benefit for the following year.*
**This benefit is available to those on Active/Cobra coverage or Non-Medicare Retirees.*
**Both Member & Spouse (if applicable) must return form to qualify*