Love Canal Medical Fund, Inc.

Annual Physical Examination Claim Form

(Limited to $350.00 per beneficiary per year. Please note that the Medical Benefit Claim Form must be used for any other expense reimbursement claim.)

Beneficiary's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurance Company: _____ Insurance Certificate #: _____

Social Security Number: (***first time filers only***) _____ - ____ - _____

Date of Physical Examination: _____

Health Care Provider / Physician's name: _____

Provider's / Physician's Telephone Number: _____

Provider's / Physician's address: _____

City: _____ State: _____ ZIP: _____

Laboratory Work

Name of Laboratory: _____

Address: _____

City: _____ State: _____ ZIP: _____

Total cost of Physician / Provider: $ _____ ._____

Total cost of laboratory work: _____ ._____

Amount paid by insurance, federal / state health plans: _____ ._____

Amount beneficiary is submitting for reimbursement: _____ ._____

Make check payable to: _____

Address (if different from above): _____

Please attach a COPY of receipts to this form. DO NOT send your only copy.

Mail completed form to: **Key Insurance & Benefits Services**
Attn: Love Canal Medical Fund
239 Van Rensselaer Street
Buffalo, NY 14210

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