W F RETIREES' HEALTH TRUST

DENTAL / HEARING / VISION

REIMBURSEMENT CLAIM FORM

SUBMIT CLAIM TO:

Bodon, Inc
9101 E Chenango Ave,
Greenwood Village, CO 80111-1321
855 937-3847 Voice and Fax

To Be Completed and Submitted by Retiree (or Their Representative)

Date: __________ / _______ / ________

Member Name (Last, First, Middle) ____

Member Address | City | State | Zip Code

____

Member's Birth Date __________ / ______ / _______

I certify the services and charges which are described herein, for which the Detailed Billing with a description of services provided is attached, and for which payment has already been made, were incurred by the member on account of the member.

I hereby authorize the release of information contained in, or pertaining to this claim to the Administrator, Trustee, or any of their authorized representatives for purposes of settlement of this claim. Misrepresentation may disqualify member from future benefits.

Person Completing Claim

Name: ____________________________ Relation: _________________________

Signature: ____________________________ Telephone: _________________________

Send reimbursement to: ______________________________

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Assignments Not Accepted

Included with this Claim are copies of:

- ❑ Detailed Billing from Provider
- ❑ Proof of Payment by Retiree