



PENNSYLVANIA FACULTY

HEALTH AND WELFARE FUND

P.O. Box 60430
Harrisburg, Pennsylvania 17106-0430

Telephone: (717) 233-4776

WELLNESS EXAMINATION PLAN

**Both Sides of This Form Must Be Completed
in Order to Qualify For This Benefit**

1. Member's Name: _____
2. SS #: _____
3. Home Address: _____

4. University: _____
5. Patient's Name: _____
6. Birthdate: _____
7. Patient's Relationship to Member: _____ Spouse
 _____ Member
8. Member's Signature: _____ Date: _____
9. Benefits may not be assigned to your doctor. Payment for services will be made to you by the Fund. This completed claim form must be submitted within three months after the date on which the physical examination was performed.
10. Submit to: Wellness Examination Plan
 Pennsylvania Faculty Health & Welfare Fund
 P.O. Box 60430
 Harrisburg, Pennsylvania 17106-0430

—SIDE A—

To be Completed By Member

REV. 3/00

