Illinois HBPA Benefit Trust Application for Assistance

Medical _____ Dental _____ Other _____

Name _____

SSN _____ Birth date _____

License Type: Trainer _____ Other _____

Employer: _____

Claim for: _____

Do you have health insurance? _____

I certify that all answer given are true. I hereby authorize the HBPA to receive information concerning my request for assistance.

Date: _____ Signature: _____

Committee Review: _____

_____

Approved: _____ Denied: _____

Approved: _____ Denied: _____

Approved: _____ Denied: _____

Date ----------

I _____ give my permission for the Secretary Treasurer of the H.B.P.A. to contact Doctors and Hospitals concerning my medical records for the purpose of verifying charges I have submitted.

Signed_____

Birthdate ----------