POLISH BENEFICIAL ASSOCIATION
2595 ORTHODOX STREET
Philadelphia, PA 19137

STATEMENT OF CLAIM

NAME _____Amount $ _____

ADDRESS _____ No. of Certificate _____

Complete Medical History of treatment received by deceased within two (2) years prior to death.

DATE	HOSPITAL / INSTITUTION	PHYSICIAN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and Address
of Claimant _____ Relationship
to deceased _____ AGE ____

_____ Tel No. : _____

_____ Soc. Sec. : _____

*NOTE: Please state if beneficiary is a minor

If not named beneficiary, complete the following for surviving spouse and/or all living children

NAME	AGE	ADDRESS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The undersigned certifies to the accuracy of the forgoing statement and agrees to supply the Polish Beneficial Association any further information, including all physician, hospital and institutional records confirming the facts contained in the aforesaid statements required by the Polish Beneficial Association in accordance with the terms of the certificate of insurance.

DATE: _____ Signature of Claimant _____

GROUP NO. _____

The undersigned hereby confirms the foregoing claim statement and certifies that the member paid his/her last assessment in the month of _____ 20 _____.

Date: _____Secy./Pres.
Signature of Officer of Group

- -DO NOT WRITE BELOW THIS LINE -

AMOUNT
OF CLAIM $ _____ _____

DIVIDENDS $ _____ INTEREST $ _____ TOTAL $ _____

Payment of the above is authorized to be made by the Secretary General to

_____ _____

_____ _____

as named beneficiary(ies) or person(s) having a legal right thereto.

_____

MEDICAL DIRECTOR SOLICITOR

DATED: _____ ACCEPTED: _____
SECRETARY GENERAL