



Union Plus Medical Bill Negotiating Service Application

The Union Plus Medical Bill Negotiating Service by Health Advocate provides union members with large out-of-pocket medical bills **FREE assistance** negotiating bill reductions with physicians, hospitals and other medical providers. The Service negotiates with medical providers on the union member's behalf to lower costs and establish payment plans.

Eligible medical expenses

- ☐ When you calculate your unreimbursed medical expenses, you may include expenses incurred from physicians, dentists, hospitals, surgery centers, diagnostic service providers — any medical provider. The Service attempts to negotiate any medical or dental bill regardless of insurance benefit status, including insured, underinsured, non-covered and out-of-network claims.
- ☐ Do not include expenses that were covered by your (or your family member's) health insurance. Health Advocate may not be able to fee negotiate on money that was applied towards a deductible, coinsurance or co-pay. Deductibles, coinsurance, and co-pays are the member's contracted obligation with the insurance carrier.
- ☐ Unreimbursed expenses must be at least \$400 for each medical provider.
- ☐ The service can assist will medical bills, of members, member's spouse, dependent children, parents and parents in-law.

Requirements

1. You must be a union member or union retiree.
2. You must have at least one outstanding unreimbursed medical expense of \$400 or more from a single medical provider. But there's no limit on the number of medical providers with which the service will negotiate.
3. Applicant must complete and sign this application and the Union Membership Verification form.

Applicant's Personal Information

Name: _____
First Middle Last

Home Address: _____

Street City State Zip code

Home Phone: ____/____/____ Cell Phone: ____/____/____

International/National Union: _____

Local Union Number: _____ *(example: OPEIU)*

What is the best time to call you? Please also indicate the best number to use: _____

Email address:

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- ☐ Please email me monthly Union Plus E-News with Union Plus benefit updates and consumer tips
- ☐ Please send me occasional Union Plus text alerts. *Message and data rates may apply depending on your cell plan. You can opt out of our text service at any time by replying STOP to any message that you receive.

How did you hear about this grant? (select one)

- | | |
|--|--|
| <input type="checkbox"/> Union Plus Web Site | <input type="checkbox"/> Fellow Union Member |
| <input type="checkbox"/> UnionPlusCard.com. | <input type="checkbox"/> Credit Card Statement |
| <input type="checkbox"/> Union Plus email. | <input type="checkbox"/> Mailing |
| <input type="checkbox"/> Union Publication | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Union Leader | |

Certification

I, the undersigned, certify that all of the information I have included in and with my application is true. I also certify that I have read and understand the information above.

Signature

Date

Mail completed application and membership verification form to:

Union Plus Medical Bill Service
1100 First Street, NE, Suite 850
Washington, DC 20002

Important Note: do NOT mail copies of your medical bills with your application. (The service may request this information, but only after you initiate your case with your first call to the program.)

Please allow 4-5 weeks for application processing.

When your application is approved you will be notified by email, or by postal mail if you do not include an email address. When you are notified you will be advised to contact the medical negotiation service directly. At that time, you should be prepared to provide them with documentation of your unreimbursed medical expenses of at least \$400 per medical provider, copies of medical bills, or insurance Explanation of Benefits (EOB) forms.

Questions

Call **1-800-472-2005** (representative available 9:00 a.m. to 4:30 p.m. ET. Use extension 839 after hours) and ask for the Union Plus Grant Specialist or email grants@unionplus.org.

You can also complete this application online, visit: www.UnionPlus.org/BillNegotiator

Union Membership Verification Form

To be considered for a grant, **this form must be completed by the applicant, verified by a local union representative, and sent in with the application.**

If you can't obtain verification from your local union, please contact your International union.

Union Member Information:

I, _____ verify I've been a member in good standing of
Name of union member

_____ since _____ / _____
Name of union Local Month Year

_____ Date
Signature of union member

Local Union Representative Verification:

Attention Local Union Representative:

This form is a required part of the Union Plus grant application package. Please complete it promptly and return it to the applicant, who must include it with his or her grant application.

Applications without this completed form will not be considered.

I verify that the above information is true and complete to the best of my knowledge.

_____ Title _____ Date _____
Signature of local union representative

_____ / _____ / _____
Print name of local union representative Daytime phone number

Name of Union: _____ **Local Number** _____

Street Address

_____ City _____ State _____ Zip code _____

Local President's Name: _____
First Last