

**PROCESSING OF CLAIMS REQUIRES THAT YOU FULLY COMPLETE THIS FORM.**

Have your physician or provider complete the reverse side of this form or attach itemized bills AND (if applicable) corresponding "Explanation of Payment" statements from Medicare or primary insurance. **DO NOT SUBMIT BALANCE DUE STATEMENTS.**

**EMPLOYEE INFORMATION**

Home Local Union No. \_\_\_\_\_

Name of Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_  
 Social Security No. \_\_\_\_\_ Occupation \_\_\_\_\_ Active  Retire Date \_\_\_\_\_  
 Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_ Date of Social Security Award \_\_\_\_\_  
 \*NOTE: If recently married or divorced, indicate date(s) \_\_\_\_\_

**OTHER INSURANCE INFORMATION NOTE: Attach copy of payment worksheet from other insurance or Medicare**

Do you or your dependents have **ANY** other health insurance?  YES  NO If YES please supply: \_\_\_\_\_  
 1) Name of the person insured \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_  
 2) Insured person's Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Policy No. \_\_\_\_\_  
 3) Insurance company name \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_  
 4) Address, City, State, Zip \_\_\_\_\_

**DEPENDENT INFORMATION - If claim is for a Dependent**

Name of Dependent \_\_\_\_\_ Relationship to Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Is Dependent attending school?  YES  NO Is Dependent employed?  YES  NO If YES, where?  
 Name \_\_\_\_\_  
 Address, City, State, Zip \_\_\_\_\_  
 \*NOTE: Attach letter from registrar of college/university indicating hours enrolled per semester.

**SICKNESS/INJURY INFORMATION \*Required for all claims\***

Nature of sickness or injury \_\_\_\_\_  
 Date accident occurred or sickness first began \_\_\_\_\_ Date first treated \_\_\_\_\_  
 If injured, detailed description of **HOW** and **WHERE** accident occurred \_\_\_\_\_  
 \_\_\_\_\_  
 If patient required treatment in a hospital, indicate date treated next to type of treatment:  
 1) Emergency Room \_\_\_\_\_ 2) Outpatient Surgery \_\_\_\_\_ 3) Admission - Discharge \_\_\_\_\_  
 Name of Hospital: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Name of physician(s) consulted 1) \_\_\_\_\_ 2) \_\_\_\_\_  
 Did injury or sickness occur in the course of **ANY** employment?  YES  NO  
 Have you or do you intend to file this claim under Workers' Compensation?  YES  NO

**EMPLOYEE MUST COMPLETE IF APPLYING FOR DISABILITY BENEFITS**

EMPLOYEE'S DISABILITY STATEMENT	Date Last Worked _____	Date Work Resumed _____	Might claim be covered by Workers' Compensation Law? <input type="checkbox"/> YES <input type="checkbox"/> NO
	*(Reverse side of this form MUST be completed by Employee's Physician)		

**EMPLOYEE'S SIGNATURE**

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative of any facts and or related records concerning the injury, illness, or treatment (including mental/nervous and substance abuse) of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed \_\_\_\_\_ Dated \_\_\_\_\_

