

EMPLOYEE'S INSTRUCTIONS FOR FILING A CLAIM

YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.
BE SURE EVERY ENTRY ON THIS FORM HAS BEEN COMPLETED.

USE A SEPARATE FORM FOR EACH MEMBER OF THE FAMILY AND EACH SEPARATE ILLNESS OR ACCIDENT.
ASK YOUR PRIMARY ATTENDING PHYSICIAN TO COMPLETE THE REVERSE SIDE OF THIS FORM AND RETURN IT TO YOU.
ASK OTHER PROVIDERS OF SERVICE TO GIVE YOU AN ITEMIZED BILL WHICH INCLUDES:

Patient's Name — Nature of illness or injury — Type of service — Charge for each supply of service —

PLEASE BE ADVISED THAT UNLESS THE FUND RECEIVES THIS FORM COMPLETED AND ALL NECESSARY BILLS FOR THIS CLAIM WITHIN NINETY (90) DAYS OF OCCURRENCE, YOU MAY BE PERSONALLY RESPONSIBLE FOR ANY CHARGES INCURRED.

POR FAVOR ESTE ADVERTIDO A NO SER QUE ESTE FONDO RECIBIA UNA PLANILLA COMPLETADA Y TODOS LOS COBROS Y RECIBOS DENTRO D NOVENTA (90) DIAS, USTED SERA RESPONSABLE FOR CUALQUIER COBRO QUE OCURIA.

Name of Employer: _____

MEMBER'S STATEMENT

1. Member's Full Name _____ Date of Birth _____ Sex _____
Street and No. _____ City _____ State _____ Zip Code _____
2. Social Security No. _____ Home Phone No. _____
3. Are you married? Yes No If Yes, is your spouse employed? Yes No If Yes, name of spouse _____
and name and address of employer _____
4. *If claim is made on behalf of one of your dependents, answer these questions in addition to all other questions.*
(a) Name of Dependent _____ Date of Birth _____ Relationship to you _____ Married
Single
(b) *If employed, other than spouse, name of employer* _____
(c) *If not employed, how long has Dependent been entirely supported by you?* _____
5. Date sickness began or injury occurred _____ Date first medical expense incurred _____
6. State fully nature of sickness or injury _____
7. If injured, state fully, how and where injury occurred _____
Did injury occur while on duty? _____
8. Has claim been filed or will claim be filed under Workmen's Compensation Act or similar law? _____
9. Are any of the expenses for which claim is being made covered by: (Include any plan or insurance carried by a dependent)
(a) Any other group insurance or any medical plan because of membership in a group? Yes No
(b) Any group Blue Cross, Blue Shield, or other prepayment plan? Yes No
(c) Any medical plan sponsored by a school or college? Yes No
If the answer to any of the above is "Yes", show below:
(a) Name and address of employer (if a plan through an employer): _____
(b) Name of the organization or insurance company (if any plan other than through an employer): _____

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim to the plan sponsor.

SIGN HERE



(Member's Signature)

(Date)

DO NOT WRITE IN THIS SPACE

WELFARE FUND STATEMENT

Eligible Member's Name _____ Date eligible _____

Signed _____

Administrator _____ Date _____

