Statement of Claim For Group Medical Expense Benefits

LOCAL UNION 831 EMPLOYER HEALTH & WELFARE TRUST FUND

MAIL TO: LOCAL UNION 831
P.O. Box 5528
El Monte, CA 91734
(626) 279-3080

HOW TO FILE A CLAIM

1. COMPLETE THIS SIDE OF FORM, ANSWER **ALL** QUESTIONS.
2. COMPLETE THE TOP PORTION OF REVERSE SIDE OF THIS FORM AND SIGN THE AUTHORIZATION TO RELEASE INFORMATION.
3. HAVE ATTENDING PHYSICIAN COMPLETE REVERSE SIDE OF FORM.
4. ATTACH ITEMIZED BILLS – **IMPORTANT** – EACH BILL MUSH SHOW:
   (1.) NAME OF PATIENT, (2.) DATE EACH EXPENSE WAS INCURRED, AND (3.) NATURE OF ILLNESS OR INJURY.
   IF THE BILL DOES NOT SHOW THIS INFORMATION, PLEASE WRITE IT ON THE BILL AND SIGN YOUR NAME.
5. FORWARD COMPLETED FORM AND BILLS TO **THE ADMINISTRATOR** IN THE SELF-ADDRESSED ENVELOPE PROVIDED.
6. **DO NOT SUBMIT ANY ON-THE-JOB INJURY OR WORKERS' COMPENSATION CLAIM.**

TO BE COMPLETED BY THE EMPLOYEE

NAME (LAST, FIRST, MIDDLE INITIAL) | **SOCIAL SECURITY NO.**

HOME ADDRESS (STREET, CITY, STATE, ZIP CODE) **IS THIS A NEW ADDRESS?** ☐ YES ☐ NO | **WEEKLY WAGE**

DATE OF BIRTH | **TELEPHONE NUMBER** | ☐ **MALE** ☐ **FEMALE** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED**

NAME AND ADDRESS OF EMPLOYER

DO YOU HAVE MORE THAN ONE EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS.

DO YOU HAVE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO IF YES, GIVE NAME, RELATIONSHIP AND FULL NAME AND ADDRESS OF EMPLOYER.

IS THIS CLAIM FOR A DEPENDENT? ☐ YES ☐ NO IF YES, GIVE NAME, DATE OF BIRTH, RELATIONSHIP MARRIED? ☐ YES ☐ NO | **SPOUSE'S DATE OF BIRTH**

NATURE OF ILLNESS | **DATE OF FIRST TREATMENT**

IS THIS CLAIM BASED ON AN ACCIDENT? ☐ **YES** ☐ **NO IF YES, COMPLETE THE FOLLOWING:**

DATE OF ACCIDENT | TIME ☐ **AM** ☐ **PM** | **WHERE DID ACCIDENT OCCUR?**

HOW DID ACCIDENT HAPPEN?

HAS CLAIM PREVIOUSLY BEEN MADE FOR THIS PERSON UNDER THIS PLAN? ☐ YES ☐ NO

HAVE YOU (OR DEPENDENT) PREVIOUSLY BEEN TREATED FOR THIS OR A RELATED MEDICAL PROBLEM? ☐ YES ☐ NO IF YES, STATE WHEN AND GIVE NAME(S) AND ADDRESS(ES) OF DOCTOR(S) AND HOSPITAL(S)

ARE ANY OF THE ILLNESSES OR INJURIES FOR WHICH THIS CLAIM IS BEING MADE RELATED TO EMPLOYMENT? ☐ YES ☐ NO

IF YOU HAVE BEEN UNABLE TO WORK, GIVE DATE OF FIRST FULL DATE NOT WORKED ..... GIVE DATE OF RETURN OR EXPECTED DATE OF RETURN TO WORK .....

ARE YOU ENTITLED TO REIMBURSEMENT OF ALL OR PART OF THESE EXPENSES THROUGH ANY OTHER COVERAGE *WHICH PROVIDES* MEDICAL BENEFITS OR SERVICES? ☐ YES ☐ NO

IF YES, GIVE NAME AND ADDRESS OF ORGANIZATION PROVIDING BENEFITS OR SERVICES

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Administrator or its representative. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's Signature if Claim is for dependent other than minor child .....

Dated ..... **Signature of Employee-Insured** .....

To authorize payment of benefits directly to your physician, complete authorization to pay benefits section on reverse side.

Administered by: ATPA