

**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 MUST 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WEEKLY WAGE			
DATE OF BIRTH	TELEPHONE NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 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 <input type="checkbox"/> AM <input type="checkbox"/> 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 WORKEDGIVE 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

