

RETURN FULLY COMPLETED MEDICAL CLAIM FORM TO:

Local 731, I.B. of T. Welfare Funds
1000 Burr Ridge Pkwy • Suite 301 • Burr Ridge, IL 60527

INSTRUCTIONS: This Claim Form is to furnish the information needed to Service your Claim. Please answer ALL questions fully.

FOR CLAIM STATUS: CALL (630) 920-1939
FOR BENEFIT INFO: CALL (630) 887-4150

MEMBER INFORMATION

Name of Member ID NO. 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

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

This claim is for Self Spouse Dependent
Name of Patient Social Sec. No. Date of Birth
Patient's Occupation Where Employed, or School, if Student
Address, City, State, Zip of Employer or School
Claim is for an accident a sickness
Briefly describe (for example: heart, fall, etc.)
Date accident occurred or sickness first began Date first treated
If injured, detailed description of HOW and WHERE accident occurred
Did injury or sickness arise in the course of ANY employment: Yes No
Have you or do you intend to file this claim under Worker's Compensation? Yes No

MEMBER'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.

Member's Signature X Date

IMPORTANT:
HAVE YOU SIGNED THIS FORM AND ANSWERED ALL QUESTIONS?