RETURN THIS FORM TO:

4TH DISTRICT IBEW HEALTH FUND
ADMINISTRATION OFFICE
9200 U.S. ROUTE 60
ONA, WV 25545
PHONE: 304-525-0331 or 888-466-9094; FAX: 304-525-6005

STATEMENT OF CLAIM
for
Group Accident and Sickness – Hospital - Surgical - Medical Benefits

IMPORTANT: COMPLETE CLAIM FORM FULLY AND ACCURATELY. FILING OF FALSE CLAIMS WILL RESULT IN LEGAL ACTION TO THE FULLEST EXTENT POSSIBLE AND THE DENIAL OF FUTURE BENEFITS.

PART 1 – EMPLOYEE COMPLETES IN ALL CASES

Social Security No. _____

1. Name of Employee _____ Date of Birth _____
2. Home Address _____ Married ❑ Single ❑
   (No. and Street / City / State / Zip)
3. Employed by _____ Occupation _____
4. Name of Spouse _____ Employed by _____

   Spouse's Insurance Carrier _____ Address _____ Effective Date _____
5. IF ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING:
   (a) When did the accident happen? Date: _____ 20____ at (hour) _____ a.m. p.m.
   (b) Was the injured person at work when the accident happened? ❑ Yes ❑ No
   (c) Was claim filed with Workman's Compensation? ❑ Yes ❑ No
   (d) Give a brief description of the accident _____
   (e) Was there a third party involved? ❑ Yes ❑ No
   (f) Was a claim filed with the third party's liability insurance for this claim? ❑ Yes ❑ No

IF PATIENT IS THE EMPLOYEE, ALSO COMPLETE LINES 6, 7 AND 8

6. On what date were you first totally disabled by the sickness or injury? _____
7. On what date were you first treated by a physician? _____

   On what date did you last work? _____
8. Have you returned to work? _____ (a) If so, on what date? _____ (b) If not, when do you expect to return to work? _____

IF PATIENT IS A DEPENDENT, COMPLETE LINE 9

9. Dependent's description:

   Name _____ Relationship _____

   Date of birth _____ Sex _____ Single ❑ Married ❑

   If child is 19 years old or older is (s)he attending school on a full-time basis? ❑ Yes ❑ No

   Name of School _____

*Was Dependent injured during course of any employment? ❑ Yes ❑ No **Date Of Injury** _____

10. Are any other group benefits provided to you or your dependents? ❑ Yes ❑ No
    (a) If your answer is "YES", please give the name and policy number and address of the insurance Plan or Company:

    _____

11. I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability to 4TH District IBEW Health Fund. A copy or photocopy of this authorization shall be valid as the original.

Date this Claim Form Signed _____ Employee's Signature _____ X EMPLOYEE SIGN HERE

THE ATTENDING PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM.
ITEMIZED BILLS MUST ACCOMPANY CLAIMS FOR HOSPITAL CARE.

PART 2 – ATTENDING PHYSICIAN'S STATEMENT

1. Patient's name _____ Age _____ Accident Case? _____ (Yes or No)

2. Nature of sickness or injury (Describe complications, if any) _____

_____

3. Did this sickness or injury arise out of patient's employment? Yes _____ No _____

If "Yes," explain _____

_____

Date of illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Mo.	Day	Yr.	Date Patient First Consulted You for this Condition	Mo.	Day	Yr.	Has Patient ever had Same Similar Symptoms? ❑ Yes ❑ No

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	(Explain unusual services or circumstances)	D DIAGNOSIS CODE	E CHARGES	F

4. The patient has been continuously disabled (unable to work) from _____, 20 _____ through _____, 20 _____

If still disabled, when should patient be able to return to work? _____, 20 _____.

5. To your knowledge, does patient have other health insurance or health plan coverage? If "Yes," identify.

Yes ❑ _____ No ❑

Date _____, 20 _____ Signed _____ M.D.
(Please Print. Then Sign Above Your Printed Name)

Physician's T.I.N. _____ Address _____
(Must be furnished under authority of law.)

PART 3 TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS, TO HOSPITAL, SURGEON OR PHYSICIAN IS DESIRED. (This assignment may not be honored if signed by a dependent or person other than the employee.)

EMPLOYEE'S ASSIGNMENT (Indicate which benefits are assigned)

I hereby assign:

❑ Hospital Expense Benefits to the Hospital
❑ Surgical Expense Benefits to the Surgeon
❑ Medical Expense Benefits to the Physician

(Read before signing) DATED _____ SIGNED _____
(Signature of Employee)

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