

RETURN THIS FORM TO:
4TH DISTRICT IBEW HEALTH FUND
ADMINISTRATION OFFICE
3150 U.S. ROUTE 60
ONA, WV 25545

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.m.
- (a) When did the accident happen? Date: _____ 20____ at (hour) _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	-----	-----	-----	---	-----	-----	-----	--

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

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 I hereby assign: Hospital Expense Benefits to the Hospital
 Surgical Expense Benefits to the Surgeon
 Medical Expense Benefits to the Physician
(Indicate which benefits are assigned)

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

RETURN THIS FORM TO:
 4TH DISTRICT IBEW HEALTH FUND
 ADMINISTRATION OFFICE
 3150 U.S. ROUTE 60
 ONA, WV 25545