STATEMENT OF CLAIM

INSULATORS LOCAL 84
HEALTH CARE PLAN TRUST FUND
33 FITCH BLVD.
AUSTINTOWN, OH 44515

THIS FORM SHOULD BE COMPLETED AND RETURNED IMMEDIATELY

MEMBER'S NAME IN FULL (PRINT)	AGE	SEX	MEMBER'S SOCIAL SECURITY NUMBER	MEMBER'S LOCAL UNION NUMBER

IF CLAIM FOR DEPENDENT COMPLETE THIS LINE ALSO, NAME OF DEPENDENT	6. RELATIONSHIP	7. DATE OF BIRTH	8. SEX	9. MARRIED OR SINGLE

MEMBER'S HOME ADDRESS (number and street)	CITY	STATE	ZIP CODE

NAME OF EMPLOYER

HAVE YOU FILED FOR UNEMPLOYMENT COMPENSATION? IF SO, WHAT DATE?

DOES THIS CLAIM COME UNDER WORKMEN'S COMPENSATION?

NAME OF ATTENDING PHYSICIAN

DATE LAST WORKED	19. DATE DISABLED

INSTRUCTIONS:

If claim is for member:

1. Complete member's Statement.
2. Have last employer complete employer's statement.
3. Have your physician complete physician's statement.

If claim is for dependent:

1. Complete all of member's statement.
2. Have physician complete physician's statement

If your claim is due to an accident, please answer the following:

HOW:

WHEN:

WHERE:

Is this condition due to an accident for which another party is responsible? ☐ Yes ☐ No

DATE ABLE TO RETURN TO WORK	DATE RETURNED TO WORK

NOTICE: The Schedule of Benefits established by your Medical Fund has provisions both for Co-ordination of Benefits and for Subrogation procedures. For details, refer to your Plan Booklet.

THIS SECTION MUST ALSO BE COMPLETED

Are you or your dependent insured under any other Group Insurance or Government plan such as Medicare, which will also pay for any of the medical expenses of the claim? ☐ Yes ☐ No If yes, give name of Insurance Company or organization providing benefits.

Address	Policy No.

Name of Spouse	Is Spouse Employed? ☐ Yes ☐ No

Name and Address of spouse's employer

Name of Attending Physician

I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim, to this Insurance Fund. A photostat of this authorization shall be as valid as the original.

Member's Signature _____ Date Signed _____

Spouse should also sign here _____ Date Signed _____

EMPLOYER'S STATEMENT

NAME OF EMPLOYEE	OCCUPATION	DATE LAST WORKED	DATE RETURNED TO WORK	REASON NOT RETURNED YET:

DATE SIGNED	SIGNED BY (title)	NAME OF EMPLOYER:	WAS DISABILITY INCURRED ON THE JOB?

ATTENDING PHYSICIAN'S STATEMENT
THIS FORM SHOULD BE COMPLETED AND RETURNED PROMPTLY.

1. PATIENT'S NAME AGE

ADDRESS

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

IS DISABILITY DUE TO PREGNANCY ☐ YES ☐ NO

IF "YES", WHAT WAS APPROXIMATE DATE OF COMMENCEMENT OF PREGNANCY?

4. NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY (describe fully) PERFORMED — FEE CHARGED — 5. DATE

6. GIVE DATES OF TREATMENTS AND FEES CHARGED	DATE TREATED	TREATMENT AT (✓) HOME	HOSPITAL	OFFICE	C.P.T. CODE	FEE

7. WHAT OTHER SERVICES, IF ANY, DID YOU PROVIDE PATIENT? (Itemize, giving dates and fees)

8. THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM ____/____/____ THROUGH ____/____/____

IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK?

9. REMARKS:

(Type or Print)

☐ **New Address**

Name _____

Address _____

City, State, Zip _____

To comply with the I.R.S. regulation No. 301.6109-1, all claims missing either the Social Security No. or Taxpayer Identification No. will be processed unassigned, with the payment going to the subscriber.

Social Security No. | or | Taxpayer Identification No.

DATE	ATTENDING PHYSICIAN'S SIGNATURE	M.D. D.C. D.P.M. D.O. D.D.S. Ph. D.

CLAIM PAYMENT AUTHORIZATION

The member hereby authorizes the Fund, at its option, to issue indemnity checks to the provider rendering services described hereon.

_____
Signature of subscriber for authorization only