PLUMBERS AND PIPEFITTERS LOCAL UNION 396
HEALTH AND WELFARE FUND

33 FITCH BLVD
AUSTINTOWN, OHIO 44515
(330) 270-0453 Fax: 330)270-3582

STATEMENT OF CLAIM

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

NAME OF EMPLOYER	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? o Yes o No
HAVE YOU FILED FOR UNEMPLOYMENT COMPENSATION? IF SO, WHAT DATE?		
DOES THIS CLAIM COME UNDER WORKMEN'S		
NAME OF ATTENDING PHYSICIAN		
DATE LAST WORKED		DATE ABLE TO RETURN TO WORK / DATE RETURNED TO WORK
DATE DISABLED		

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? DYes D 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 0 YES 0 NO ______________________

IF "YES", EXPLAIN ____

- o 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.	DATE TREATED	TREATMENT AT (PLEASE CHECK)				FEE
		HOME	HOSPITAL	OFFICE	C.P.T. CODE	
GIVE DATES OF						
TREATMENTS AND						
FEES CHARGED						

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: ____

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____.

(Type or Print)

- o 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. ______________________

Taxpayer Identification No. ______________________

DATE ____________ ATTENDING PHYSICIAN'S SIGNATURE ______________________

M.D. D.P.M. D.D.S. D.C. D.O. 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

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