CLAIM FORM

This is my family's first claim with Local #33 _____
yes or no

If "no" give approximate date of last claim _____

Sheet Metal Workers Local #33, Youngstown District
Health and Welfare Fund
33 Fitch Blvd
Austintown, Ohio 44515
(330) 270-0453 or Toll Free 1-800-435-2388

INSTRUCTIONS: Every item must be completed in full by your self and your doctor. Send this form and the ITEMIZED hospital, surgical and medical bills to *your* Welfare Fund Office for completion of claim for such benefits. Claims cannot be considered unless these instructions are STRICTLY COMPLIED WITH. You MUST file claim form and ALL bills within 90 days of your disability.

PLEASE PRINT EMPLOYEE STATEMENT PLEASE PRINT

1. Employees Name _____

2. Employees full street address _____

City and State _____ Zip Code _____

3. Member of Local Union No. _____ Occupation _____ Soc. Sec. No. _____

4. Presently employed by _____ Company Address _____

IF THIS CLAIM IS FOR A DEPENDENT, ALSO FILL OUT THIS PART

5. Print Dependent Name_____ Dependent Soc. Sec. No. _____

6. Relationship to Employee _____ Dependent Date of Birth _____

7. Are any other members of your family employed? No __ Yes ___ If "Yes," please describe below:
Name Relationship _____ Employer's Name _____
Name Relationship Employer's Name _____

8. Are you or your dependents entitled to benefits from any Group Insurance or Group Prepayment plan for hospital, surgical or medical expense or services? No __ Yes _____ If "Yes," indicate name and address of
a. Employer _____ _____
b. Insuring Organization _____ _____

NOTE: If insured by an additional Group Insurance Company, please *supply BOTH* companies *with all related bills*

9. Was claim due to accident? _____ Where _____ Date _____

Was claim due to illness? _____ Where _____ Date _____

10. If claim is for an accident (or illness), describe briefly. _____
_____
_____

11. Have you or do you intend to present a request for State Workers' Compensation arising out of this disability?

Yes No

OHIO INSURANCE FRAUD WARNING

Ohio Law requires that we provide you with the following warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an Insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud

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 the attending Physician to release any information acquired in the course of my examination or treatment.

Date: _____ Signed, _____

EMPLOYEE'S ASSIGNMENT (Read Before Signing)

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS TO THE HOSPITAL, PHYSICIAN OR SURGEON IS DESIRED. NOTE: ONCE BENEFITS ARE ASSIGNED, THE ASSIGNMENT CANNOT BE REVOKED.

(This assignment may not be honored if signed by a dependent or person other than the employee)

I hereby assign: Hospital Expense Benefits to the Hospital
Medical Expense Benefits to the Physician
Surgical Expense Benefits to the Surgeon

Date _____ Signed _____
Signature of Insured Employee

ATTENDING PHYSICIAN'S STATEMENT - DOCTOR MUST COMPLETE THIS FORM FOR PAYMENT OF SURGICAL, MEDICAL AND WEEKLY BENEFITS

Dear Doctor:
Please fill out and sign this form. Return It to:

Sheet Metal Workers #33, Youngstown District, Health and Welfare Fund
33 Fitch Blvd, Austintown, Ohio 44446

Patient's Name and Address _____Age_____

1.a.	Diagnosis and concurrent conditions (If fracture or dislocation, ~describe nature and location)	
b.	Is condition due to injury or sickness arising out of patient's employment? If "Yes", explain	Yes No
c.	Is condition due to pregnancy?	Yes No
2.a.	When did symptoms first appear or accident happen?	Date _____
b.	When did patient first consult you for this condition?	Date _____
c.	Has patient ever had same or similar condition? If "Yes", state when and describe.	Yes No
3.a	Nature of surgical or obstetrical procedure, if any (Describe Fully)	Date performed _____
b.	Charge to patient for this procedure including post-operative care	$ _____
c.	If performed In hospital, give name of hospital	Inpatient Outpatient
4.a	Give dates of other medical (non surgical) treatment, if any	Charge per call Office _____ $ _____ Home _____ $ _____ Hospital _____ $ _____ Nursing Home _____ $ _____ Total (Non-Surgical) charge $
5.	What other services, if any, did you provide patient? (Itemize, giving dates and fees)	
6	Were registered private duty nurse (R.N.) services necessary?	Yes No
7.	Is patient still under your care for this condition? If "No" give date your services terminated	Yes No Date
8	How long was or will patient be continuously Totally disabled (Unable to work)?	From thru
9.	To your knowledge, does patient have other health insurance or health plan coverage? If "Yes". identify	Yes No

Date:_____

Signature (attending physician)_____

Street Address_____

Telephone_____

INDIVIDUAL PRACTITIONERS - SS No._____

ALL OTHER - EMPLOYER 10 No.

_____

MUST BE FURNSHED UNDER AUTHORITY OF
LAW I.R.S. SECTION 6401 - Rev. Rule 69-595