LOCAL 734 WELFARE FUND

6643 North Northwest Hwy. • Chicago, IL 60631-1360 • (773) 594-2810 • FAX (773) 631-3824

EMPLOYEE'S STATEMENT

FAILURE TO COMPLETE THIS FORM IN FULL WILL DELAY THE PROCESSING OF YOUR CLAIM

MEMBER'S INFORMATION

Your Name | Date of Birth

Social Security Number | ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated | Telephone No. ( ) -

Your Complete Mailing Address

City | State | Zip Code

Name of Your Employer | Date Employed

Employment Status:
☐ Active
☐ Retired
☐ Not Employed

SPOUSE INFORMATION

Name | Date of Birth

Social Security Number | Employment Status ☐ Active ☐ Retired ☐ Not Employed

Employer Name and Address

Name and Address of Insurance Company

Policy or Plan No. | Insurance ID Number | Type of Coverage ☐ Individual ☐ Family

Effective Date / / | Coverage ☐ Medical ☐ Dental ☐ Vision

PATIENT INFORMATION

Name | Date of Birth

Relationship to Member
☐ Self ☐ Spouse ☐ Other_____
☐ Natural child living with you. ☐ Natural child not living with you. ☐ Step-Child

If Child: Married? ☐ Yes ☐ No Full-Time Student? ☐ Yes ☐ No Employed? ☐ Yes ☐ No

Child's Social Security Number

If illness describe:

Claim is for ☐ Illness ☐ Pregnancy ☐ Accident

Date first saw Doctor for this Claim mm / dd / yy

Where did accident occur?

Date Accident Occurred | _____ Time ☐ A.M. ☐ P.M.

How did accident occur?

ACCIDENT OR ILLNESS DUE TO AUTO ACCIDENT? ☐ Yes ☐ No

ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ☐ Yes ☐ No

HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? ☐ Yes ☐ No

ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED UNDER ANOTHER GROUP HEALTH PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING SECTION

Covered Family Member
☐ Self ☐ Child
☐ Spouse

If Child: _____ NAME

Name of Person with Other Coverage:_____

Relationship to Child:_____

Policy or Plan No. | Insurance ID Number | Type of Coverage ☐ Individual ☐ Family

Name and Address of Insurance Company

Effective Date / / | Coverage ☐ Medical ☐ Dental ☐ Vision

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician, or other person who has attended me or examined me or my dependents to disclose when requested to do so by Local 734 Welfare Fund or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that Local 734 Welfare Fund is to pay the hospital, as determined by Local 734 Welfare Fund, in accordance with the Plan Document, directly to the provider of the service unless paid receipts are presented.

DATE	MEMBER'S SIGNATURE	IF CLAIM FOR SPOUSE, SPOUSE'S SIGNATURE