

CLAIM REFERENCE No. _____

STATEMENT OF CLAIM

FOR

GROUP HEALTH INSURANCE BENEFITS

ELECTRICAL WORKERS BENEFIT TRUST FUND

IBEW LOCAL UNION 481

1828 N. Meridian Street, Suite 103

Indianapolis, IN 46202

Telephone (317) 923-4577 • Fax (317) 923-7633

TO BE COMPLETED BY PARTICIPANT

INSURED'S STATEMENT (PLEASE PRINT)

INSURED: Please complete and sign this portion of the claim statement. Leave no sections blank. If a question or section does not apply to this claim, please indicate "not applicable" (N/A). Failure to fully answer all questions will delay the processing of your claim. Return this completed statement promptly to the Fund Office at the address listed above.

1. INSURED'S NAME	MALE <input type="checkbox"/>	SOCIAL SECURITY NUMBER	FEMALE <input type="checkbox"/>
2. INSURED'S HOME ADDRESS (number and street) (city) (state) (zip code) (phone #)			
4. NAME OF EMPLOYER			
5. CLAIMANT (patient) If claim is for dependent, please state: Name of Dependent _____			
SELF <input type="checkbox"/>	Is dependent a full time student? Yes <input type="checkbox"/> No <input type="checkbox"/>	Relationship _____	
DEPENDENT <input type="checkbox"/>	Is dependent married? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Birth _____	
6. Describe the nature of the symptoms, illness, or accident: _____			
7. Was the claim a result of an accidental bodily injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If Yes: Date it happened _____ Place of injury: _____ (ie, home, store, work, etc.)			
How did it occur _____			
9. If claim is for insured, was/is insured disabled (unable to perform work)? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please state: Date last worked _____ Date returned to work _____			
10. Is any other party possibly liable to pay the expenses related to this injury? (ie, other driver, homeowner, etc.) Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes: Please provide the Name, Address, and Phone number of the other party and/or contact person.			
CONTACT PERSON NAME			
ADDRESS (number and street) (city) (state)(zip code) (phone #)			
If the illness or injury occurred in connection with the patient's employment (Including full, part-time or self employment). Please send a copy of the workers compensation carrier's payment or denial.			
11. NAME OF ATTENDING PHYSICIAN(S)			
12. A Subrogation Agreement must be completed for any accident outside the home other than a work related accident.			
I/We certify that the above statements are true and complete. I/We hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to furnish to the ELECTRICAL WORKERS BENEFIT TRUST FUND any additional information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.			
SIGNATURE OF INSURED			DATE

THIS GROUP INSURANCE PLAN CONTAINS A NON-DUPLICATION PROVISION WHICH REQUIRES THE COORDINATION OF THE BENEFITS OF THIS POLICY WITH ANY OTHER GROUP INSURANCE BENEFITS WHICH MAY BE PAYABLE.

NO CLAIM WILL BE CONSIDERED FOR PAYMENT UNTIL PRIMARY RESPONSIBILITY HAS BEEN DETERMINED. CLAIMS MUST BE RECEIVED BY THE ELECTRICAL WORKERS BENEFIT TRUST FUND ADMINISTRATIVE OFFICE WITHIN SIX (6) MONTHS FROM THE DATE OF SERVICE TO BE ELIGIBLE TO BE CONSIDERED FOR PAYMENT.

