

# MEDICAL CLAIM STATEMENT EMPLOYEE'S STATEMENT



1. Employee's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home Address \_\_\_\_\_ (STREET) \_\_\_\_\_ Local Union # \_\_\_\_\_  
 Telephone # \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP) \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Legally Separated  Widowed  
 Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP) \_\_\_\_\_

2. This claim is for  Self  Spouse  Unmarried son  Unmarried daughter  
 Other, explain \_\_\_\_\_

3. Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Spouse's Social Security No. \_\_\_\_\_

4. Is spouse employed?  Yes  No If yes, give name and address of employer \_\_\_\_\_

5. If dependent child is over age 18, give name and address of school being attended (if any) on a full-time basis.

NAME OF SCHOOL
ADDRESS

Are you or your dependents entitled to benefits under any other group insurance plan, Blue Cross/Blue Shield Plan, school plan or governmental plan, including Medicare:  Yes  No  
 If yes, please provide necessary information.

FAMILY MEMBER INSURED UNDER OTHER PLAN
NAME & ADDRESS OF OTHER INS. CO. OR ORGANIZATION
GROUP POLICY NUMBER

If for a dependent Name of Dependent \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Dependent's Occupation, if any \_\_\_\_\_ Is Dependent child a full-time student?  Yes  No

If for yourself Did you lose time from work because of this disability?  Yes  No  
 If yes, give date last worked before becoming totally disabled \_\_\_\_\_, 20\_\_  AM  PM  
 and date of return \_\_\_\_/\_\_\_\_/\_\_\_\_ or expected return to work \_\_\_\_/\_\_\_\_/\_\_\_\_

6. Claim is for  an Accident  a Sickness  
 Briefly describe (for example: heart, pregnancy, fall, etc.) \_\_\_\_\_  
 COMPLETE IF CLAIM IS FOR AN ACCIDENT  
 Date/Time \_\_\_\_\_ Where \_\_\_\_\_ How \_\_\_\_\_

7. Did sickness or injury arise out of or in the course of any employment?  Yes  No

I authorize any physician, hospital, insurer or any other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to this fund or their duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ Such information may be used to the extent deemed necessary to determine the validity or amount payable in regard to this claim (Parent if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_

## EMPLOYER'S STATEMENT – To Be Completed for Employee Claim Only

LAST DATE EMPLOYEE WORKED	EMPLOYER #	NAME OF COMPANY
DATE EMPLOYEE RESUMED WORK	IS THE CLAIM ONE WHICH MIGHT COME UNDER WORKMEN'S COMPENSATION OR OCCUPATIONAL DISEASE ACTS? <input type="checkbox"/> Yes <input type="checkbox"/> No	ADDRESS OF COMPANY ZIP CODE
IS EMPLOYEE STILL EMPLOYED BY YOU	SIGNATURE OF AUTHORIZED REPRESENTATIVE	TITLE DATE

CURRENT STATUS OF EMPLOYEE: LEAVE OF ABSENCE  LAID-OFF  TERMINATED  RETIRED