OFFICE USE ONLY			DATE
CLAIM #	BY	EXAM #	

PRESCRIPTION DRUG CLAIM FORM

CLAIM FORM MUST BE SUBMITTED WITHIN 90 DAYS OF LOSS.

UNION ROOFERS HEALTH & WELFARE FUND

CLAIM FORM

INSTRUCTIONS – STATEMENT OF CLAIM

1. EMPLOYEE complete Part A
2. Mail form and ALL BILLS to office at right.

MAIL COMPLETED FORM TO

UNION ROOFERS HEALTH & WELFARE FUND
9901 PARAMOUNT BLVD., SUITE 211, DOWNEY, CALIF. 90240
562-927-1434

PART A

THIS PART TO BE COMPLETED AND SIGNED BY THE EMPLOYEE CLAIMING BENEFIT FOR SELF OR DEPENDENT (Please print or type)

EMPLOYEE'S NAME (FIRST) (LAST)	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ SINGLE	NAME OF COMPANY YOU WORK FOR	LOCAL NUMBER

HOME ADDRESS (NUMBER AND STREET)	OCCUPATION	DATE OF BIRTH (EMPLOYEE)
(CITY) (STATE) (ZIP CODE)	SOCIAL SECURITY NO.	TELEPHONE NO.

CLAIM IS MADE FOR ☐ SELF ☐ SPOUSE ☐ CHILD ☐ STEPCHILD	PATIENT'S NAME (FIRST) (LAST)	PATIENT'S SS#	DATE OF BIRTH (CLAIMANT)	☐ MALE ☐ FEMALE	DATE OF BIRTH (SPOUSE)

NAME AND ADDRESS OF DEPENDANTS EMPLOYER	DEPENDANTS SOC. SEC. NO.	DO DEPENDANTS HAVE OTHER INSURANCE? ☐ YES. ☐ NO

NAME OF ANY INSURANCE CARRIER OR OTHER ORGANIZATION PROVIDING BENEFITS FOR THIS SICKNESS OR INJURY (INCLUDE DEPENDENT'S INSURANCE)	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF OTHER CARRIER	DO YOU HAVE MEDICARE? ☐ YES ☐ NO NO.
DESCRIBE SICKNESS OR INJURY	DO YOU HAVE MEDI-CAL? ☐ YES ☐ NO NO.

ARE YOU STILL ACTIVELY EMPLOYED? ☐ YES ☐ NO	IF NO, WHAT WAS LAST DATE OF ACTUAL EMPLOYMENT?	
IF DISABLED, SHOW FIRST DATE YOU WERE UNABLE TO WORK DATE: TIME: ☐ AM ☐ PM	HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	DATE OF RETURN TO WORK
WAS DISABILITY CAUSED BY YOUR WORK? ☐ YES ☐ NO	HAVE YOU FILED A CLAIM FOR THIS DISABILITY WITH THE WORKMEN'S COMPENSATION CARRIER? ☐ YES ☐ NO	RESULT ☐ ACCEPTED ☐ DENIED

WAS TREATMENT REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO — IF "YES" COMPLETE QUESTIONS BELOW:

COMPLETE IF INJURY INVOLVED

DATE OF ACCIDENT	TIME ☐ AM ☐ PM	WAS CLAIMANT AT WORK WHEN ACCIDENT HAPPENED? ☐ YES ☐ NO	FOR WHOM

PLACE AND DETAILS OF ACCIDENT

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish Union Roofers Health & Welfare Fund with full information regarding treatment rendered (including copies of their records. I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish Union Roofers Health & Welfare Fund with information regarding benefits to which I/We may be entitled. (If claim for spouse, spouse also must sign.)

ORIGINAL CLAIM FORM MUST BE SUBMITTED.

DATE	SIGNATURE (PATIENT, OR PARENT IF A MINOR)	EMPLOYEE'S SIGNATURE

CLAIM FORM MUST BE ENTIRELY COMPLETED AND SIGNED

203

Claim Must Be Submitted Within 90 Days Following Loss