RETURN COMPLETED FORM TO:

SHEET METAL WORKERS' LOCAL 265, HEALTH & WELFARE FUND

205 Alexandra Way, Carol Stream, IL 60188-2080
Phone (630) 668-7260, 668-7291
www.smw265.org • email benefits@smw265.org

EMPLOYEE'S STATEMENT

Please complete and return this form when your Physician is in the PPO. (Not be used for Loss of Time Benefits).

EMPLOYEE INFORMATION

Name of Employee _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____ Telephone No. (_____) _____

Health Card ID # _____ Occupation _____ Active ☐ Retire Date _____

Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

***Note:** If recently married or divorced, indicate date(s) _____

OTHER INSURANCE INFORMATION **NOTE: Attach copy of the explanation of benefits from other insurance or Medicare**

Do you **or** your dependents have **ANY** other health insurance? ☐ YES ☐ NO If YES please supply:

1) Name of the person insured _____ Relationship to Employee: _____

2) Insured person's ID # _____ Date of Birth _____ Policy No. _____

3) Insurance company name _____ Telephone No. (_____) _____

4) Address, City, State, Zip _____

DEPENDENT INFORMATION - If claim is for a Dependent

Name of Dependent _____ Relationship to Employee _____ Date of Birth _____

Dependent's Social Security No. XXX - XX - _ _ _ _ (last four digits)

Is Dependent attending school? ☐ YES ☐ NO Is Dependent employed? ☐ YES ☐ NO If YES, where?

Name _____

Address, City, State, Zip _____

***NOTE:** Attach letter from registrar of college/university indicating full or part-time status per semester.

SICKNESS/INJURY INFORMATION *Required for all claims*

Nature of sickness or injury _____

Date accident occurred or sickness first began _____ Date first treated _____

If injured, detailed description of **HOW** and **WHERE** accident occurred _____

_____

Was there any hospital confinement, emergency room care or out patient surgery for this claim? If so, please complete information below:

Type of Treatment	Dates of Treatment	Name of Hospital or Out Patient Facility
_____	_____	_____

Name of physician(s) consulted 1) _____ 2) _____

Did injury or sickness occur in the course of **ANY** employment? ☐ YES ☐ NO

Have you or do you intend to file claim under Workers' Compensation? ☐ YES ☐ NO

If Accident, will claim be made against any auto insurance carrier or third party liability insurance carrier? ☐ YES ☐ NO

EMPLOYEE'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts and/or related records concerning the injury, illness, or treatment (including mental/nervous and substance abuse) of myself or my dependents. The Trustees and/or their representatives may use requested health information for purposes of making or obtaining payment for care and conducting health care operations as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A photocopy of this authorization shall be considered as effective and valid as the original.

Employees Signature _____ Dated _____ 20 ____

If claim for dependent over 17, Dependent's Signature _____ Dated _____ 20 ____