IMPORTANT — READ CAREFULLY!

1. Fill out Participant's Section, making sure that **Member** signs Claim Form and all Assignment of Benefits, if payment is to be made directly to Provider.
2. Have your Employer complete his Section if Time Loss involved.
3. Have your Doctor complete reverse side, attach all bills and include Dates of Disability, if Time Loss involved.
4. Answer all questions, to assure prompt service of your Claim.
5. Claim must be filed within 90 days.
6. Non-Emergency Surgery may require you to call this office for second opinion.

Mail Completed Form and Bills to:

CONTRACTORS, LABORERS, TEAMSTERS and ENGINEERS HEALTH and WELFARE PLAN
10334 Ellison Circle • Omaha, NE 68134
Telephone: 402-491-3751 • FAX 402-491-0902

Eligibility YES	Hours	Unemployment	Loss of Time	Reciprocity
NO				

STATEMENT OF CLAIM FOR BENEFITS

TO BE COMPLETED BY COVERED MEMBER

1. Member's full name____ Soc. Sec. Number____ Date of birth____ ☐ Male Sex: ☐ Female
   Home Address____ (Number and Street / City / State / Zip Code) Telephone number____
   Employed by____ Local or Occupation____ Date employed____
2. Claim is made for: (Check one) ☐ Self ☐ Dependent—Name____ Relationship to Member____ Date of birth____ ☐ Male Sex: ☐ Female
   Dependent's marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally separated
3. Date accident occurred or sickness began____, ____ ☐ A.M. ☐ P.M.
4. Describe injury or sickness____
5. Date of first treatment for this injury or sickness____, ____
6. IF INJURED:
   a. Where did the injury occur?____ Date and hour____
   b. What was claimant doing when the injury occurred?____
   c. Describe injury: Tell how it happened____
7. Was the injury or sickness caused by any employment? ☐ Yes ☐ No
8. Has there been, or will there be, a claim filed for this disability with the workmen's compensation carrier? ☐ Yes ☐ No
9. First full day unable to work____, ____ Date returned to work____, ____ Date expected to return to work____, ____
10. If married, is your spouse employed? ☐ Yes ☐ No Name of your spouse____
    Name of your spouse's employer____ Address of your spouse's employer____
    Does spouse have group insurance at place of employment? ☐ Yes ☐ No If "yes", give name and address of the insurance company.
    ____ Spouse's Policy No.:____
    Spouse's Social Security No.:____ Spouse's Date of Birth ____
11. Are any hospital, surgical or medical benefits or services provided under any group plan other than shown under question 10, or under any federal, state or other governmental program? Also, is above claim covered under any third-party insurance?
    ☐ Yes ☐ No If "yes," give name and address of insurance company or organization providing such benefits or services____
12. I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.
13. I wish to assign all benefits payable direct to all providers. Yes ☐ No ☐
14. Date____, ____ Member's signature____ Member Sign Here

TO BE COMPLETED BY EMPLOYER IF TIME LOSS INVOLVED (Please Type)

1. first full day unable to work____, ____ Date returned to work____, ____ Date expected to return to work____, ____
2. Is there any possibility this disability was caused by employment? ☐ Yes ☐ No If "yes," explain____
3. Name of employer____
4. Date____, ____ Signed____ (Name / Title)

PLEASE HAVE OPPOSITE SIDE COMPLETED BY ATTENDING PHYSICIAN
BE SURE ALL BILLS ARE FORWARDED WITH THIS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Spaced for Typewriter — Marks for Tabulator Appear on This Line • • • • • • • •

Patient's name and address Age

Member's name if patient is a dependent

For non-emergency surgery was second opinion acquired? Yes ☐ No ☐

Diagnosis and concurrent conditions
(If fracture or dislocation, describe nature and location.)

Is condition due to injury or sickness
arising out of patient's employment? If "yes" explain. Yes ☐ No ☐

Is condition due to pregnancy? If "yes" what was approximate date of commencement of pregnancy? Yes ☐ No ☐ Date_____

When did symptoms first appear or accident happen? Date_____

When did patient first consult you for this condition? Date_____

Has patient ever had same
or similar condition? If "yes" state when and describe. Yes ☐ No ☐

Nature of surgical or obstetrical
procedure, if any. (Describe fully.)

Date performed_____

Charge to patient for this procedure including post-operative care. $_____

If performed in hospital, give name of hospital. Inpatient ☐ Outpatient ☐

Give dates of other medical (non-surgical) treatment, if any. Charge per call

Office_____ $_____

Home_____ $_____

Hospital_____ $_____

Total (non-surgical) charges $_____

Is patient still under your care for this condition?
If "no" give date your services terminated. Yes ☐ No ☐ Date_____

How long was or will patient be continuously totally disabled
(Unable to work?) From_____ Thru_____

To your knowledge does patient have other health
insurance or health plan coverage? If "yes" identify. Yes ☐ No ☐

Date Type or print physician's name and degree

Signature (attending physician) I. D. Number Telephone

Street Address City or Town State or Province Zip Code