CLAIM FOR MEDICAL EXPENSE BENEFITS

FOR INTERNAL USE ONLY

HOW TO FILE YOUR CLAIM: SEE REVERSE SIDE

NOTICE—A person commits a criminal act if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a Statement of Claim that contains any materially false information; or (2) Conceals, for the purpose of misleading, information about any fact that is material to a claim. Violations are subject to criminal prosecution and may also result in civil penalties.

MAIL COMPLETED CLAIM TO:

Electrical Workers Benefit Fund
906 Minoma Avenue
Louisville, KY 40217

PART I — EMPLOYEE'S STATEMENT — Please Print

EMPLOYEE'S NAME (Last, First, M.I.)

SEX ☐ Male ☐ Female

DATE OF BIRTH / /

EMPLOYEE'S ADDRESS (No., Street)

HOME TELEPHONE NUMBER

(City, State, Zip Code)

SOCIAL SECURITY NUMBER

MARITAL STATUS

SPOUSE'S NAME (Last, First, M.I.)

IS SPOUSE EMPLOYED? ☐ Yes ☐ No

IF "NO" HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? ☐ Yes ☐ No

NAME AND ADDRESS OF SPOUSE'S EMPLOYER

SPOUSE'S DATE OF BIRTH

Are you or your dependent(s) covered under another group insurance or government plan such as Blue Cross/Blue Shield, Medicare, an HMO or Automobile Mandatory No-Fault Coverage which will also cover any of the medical expenses or disability losses of this claim?

☐ Yes ☐ No If "Yes" give name of insurance company, first benefit insurer, organization, or HMO providing benefit

NAME AND ADDRESS OF BENEFIT CARRIER

POLICY NUMBER

PATIENT'S NAME

DATE OF BIRTH / /

RELATIONSHIP TO EMPLOYEE

PATIENT'S SOCIAL SECURITY NUMBER

DESCRIPTION OF ACCIDENT OR ILLNESS

ACCIDENT OR ILLNESS WAS DUE TO EMPLOYMENT ☐ Yes ☐ No

INJURY DUE TO AUTO ACCIDENT ☐ Yes ☐ No

DATE OF ACCIDENT OR BEGINNING OF ILLNESS

HAVE YOU OR YOUR DEPENDENT OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKER'S COMPENSATION BENEFITS ☐ Yes ☐ No

PART II — EMPLOYEE'S RELEASE AUTHORIZATION

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health to give any such information to the Fund and its legal representatives: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person, any employer, group plan holder or certificateholder.

I understand that the information released to the Fund will be used in processing my claim for medical benefits, the Fund may redisclose such information for that purpose to the employer or union connected with the group medical benefits involved herein, or their representatives, to any reinsurer, to my spouse and to any person or entity performing a business or legal function for the benefit of the Fund. This information may also be redisclosed as otherwise specifically permitted or required by law. This authorization or photocopies of it will be valid for the term of the coverage of the plan. The information released to the Fund will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

SIGNATURE OF EMPLOYEE

DATE

SIGNATURE OF DEPENDENT PATIENT (PARENT SHOULD SIGN FOR MINOR CHILD)

DATE

PART III — EMPLOYEE'S AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER

I hereby authorize payment directly to the provider named below on this claim for the medical benefits otherwise payable to me, but not to exceed the charges shown below. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE OF EMPLOYEE

DATE

PART IV — PROVIDER'S STATEMENT — To be completed by Provider of Medical Services — Please Print

NAME OF MEDICAL PROVIDER (Last, First, M.I.)

DEGREE

STATE LICENSE NUMBER

PROVIDER'S ADDRESS (No., Street)

TELEPHONE NUMBER ( )

PHYSICIAN TAXPAYER (IRS) IDENTIFICATION NUMBER/SOCIAL SECURITY NUMBER

(City, State, Zip Code)

NAME OF PATIENT (Last, First, M.I.)

DATE YOU FIRST TREATED PATIENT FOR THIS CONDITION

☐ Yes ☐ No Are charges assigned? If "Yes", "PART III — EMPLOYEE'S AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER" must be completed, signed and dated by the employee. Dependent signatures will not be considered valid assignment.

DESCRIPTION OF SERVICE	ICD-9-CM DIAGNOSTIC CODE	DIAGNOSIS (Medical Term)	PLACE OF SERVICE CODE	DATE(S) OF SERVICE	CPT 4 PROCEDURE CODE	CHARGE

NOTE: For surgical procedures, please provide operative and/or pathology reports.

I hereby certify that services listed have been performed and that the fees charged do not exceed the fees charged my private and non-insured patients, nor am I a relative of this patient. This information is complete and accurate to the best of my knowledge. I understand that this claim is subject to the review and approval and that verbal approvals of claim are not binding unless confirmed in writing.

PROVIDER'S SIGNATURE

DATE

Use this form to submit a claim for medical expenses

MAIL COMPLETED CLAIM TO:
Electrical Workers Benefit Fund
906 Minoma Avenue
Louisville, Kentucky 40217

Instructions for Completing Medical Claim Forms

To ensure a prompt handling of your claim, complete this form as described below:

- The employee completes Part I
  A separate form should be completed for each family member for whom a claim is submitted.
- The Medical Provider completes Part IV with detailed claim information.

On a continuing claim we will accept detailed itemized bills from your medical provider. These must include:

a) Name and address of provider(s) of service
b) Patient's name
c) Description of services rendered or items purchased
d) Diagnosis and ICD – 9 – CM code
e) Date(s) on which services were rendered or items were purchased
f) CPT procedure code(s)
g) Itemization of charges

- Include with your submission corresponding allowance or denial statements from other medical plans, such as Medicare, No-Fault automobile coverage, Worker's Compensation, or any other medical plan for yourself or your dependents, should be included in your submission.

NOTE: If you wish benefits to be paid directly to the medical provider, please complete Part III of this form.