MEDICAL CLAIM FORM

PLUMBERS & FITTERS LOCAL 101 HEALTH AND WELFARE FUND

All Claims should be mailed to:
Midwest Association of Health & Welfare Funds
4709 44th Street Suite 4
Rock Island, IL 61201

PART 1: MUST BE COMPLETED BY PARTICIPANT

Participant's Name:			Participant's Social Security No.
Home Address:			Participant's Birth Date:
City	State	Zip Code	Spouse's Birth Date:
☐ Please check this box if the address you entered is a new address			
Home Phone No:	Patient's Name (If other than Participant):		Male ☐ Female ☐
Patient Relationship to Participant:	Is Patient Full-Time Student? Yes ☐ No ☐	Is Patient Married? Yes ☐ No ☐	Patient's Birth Date:
Name and Address of School if Student			Is Patient Employed? Yes ☐ No ☐
Name and Address of Patient's Employer:			
Nature of Sickness, Injury, Reason why treatment was sought:			
Date Admitted if Hospitalized:		Date Accident or Sickness Began:	
If Injured, How, When and Where Did Accident Happen?			Automobile Accident? Yes ☐ No ☐
If an Injury, was a Third Party at Fault? Yes ☐ No ☐	Name of Third Party?	Address of Third Party:	
Name and Address of Third Party's Insurance:			Third Party's Phone Number:
Is Claim Due To An On-The-Job Illness or Injury? Yes ☐ No ☐	Have you filed a Claim with Workers' Compensation? Yes ☐ No ☐	Physician's Name:	
Name of Spouse:		Name and Address of Spouse's Employer:	

Is the patient covered under any other Group Plan, Health Maintenance Organization, Government Plan or Insurance Policy which would cover any of the expenses of this Claim? Yes ☐ No ☐ If yes, give name, address and policy number of plan providing benefits.
Plan Name And Address: Policy No.

PATIENT OR PARENT PLEASE SIGN BELOW

Certification and Permission to Release Information:

I hereby certify that the above information is true and correct to the best of my knowledge; I understand that falsification or withholding of material facts may result in loss of benefits and other serious consequences.

For the purposes of determining eligibility for benefits and claim processing, I hereby permit Midwest Association of Health & Welfare Funds and/or Plumbers & Fitters Local 101 Health & Welfare Fund to receive from and provide to medical practitioners, medical-related facilities, insurance companies, other health plans and other parties involved in claims processing information as to any physical or mental condition of myself or my covered dependents. I know that I have a right to receive a copy of this agreement and I grant that a photocopy is as valid as the original.

_____ **Date:**_____

Patient or Parent if Minor