TEAMSTERS LOCAL 641 WELFARE FUND
714 RAHWAY AVENUE
UNION, N. J. 07083
Phone: (908) 687-4488

EMPLOYEE'S CLAIM FORM

INSTRUCTIONS — The employee and doctor should complete this form IMMEDIATELY AFTER DISABILITY BEGINS AND mail it to 714 Rahway Ave., Union, N. J. 07083. Any benefits to which the employee is entitled will be paid directly to the *employee* unless the employee signs the "Authorization to Pay" portion* of this form below *and the name of the payee is entered.*

If surgical or medical benefits are claimed, itemized bills showing *diagnosis, nature* and *dates of treatment or surgery* should be obtained if this information is not included on the Physician's Statement.

FALSE ANSWERS TO ANY QUESTIONS OR SUBMISSION OF FRAUDULENT BILLS MAY RESULT IN THE LOSS OF ALL BENEFITS AND POSSIBLE CRIMINAL PROSECUTION.

ANSWER ALL QUESTIONS

THIS FORM WILL BE RETURNED TO YOU IF EMPLOYEE DOES NOT ANSWER ALL QUESTIONS

EMPLOYEE'S STATEMENT

NAME OF EMPLOYEE (PLEASE PRINT) _____ SS No. _____ TEL. No. _____

STREET ADDRESS _____ CITY AND STATE _____ ZIP CODE _____

DATE OF UNION MEMBERSHIP _____ LOCAL No. _____ REASON FOR TREATMENT _____

WHEN WERE YOU FIRST UNABLE TO WORK? (DATE) (HOUR) _____ WERE YOU INJURED IN COURSE OF ANY EMPLOYMENT? IF YES, GIVE FULL EXPLANATION _____

IF INJURED, HOW, WHEN AND WHERE DID ACCIDENT HAPPEN? (In the event that some other carrier or entity is primarily responsible for payment of expenses, such as those for which you are now making claim please be advised that this Fund has a Right to Subrogation which it may exercise to recover its payments.)

WILL THERE BE ANY LAW SUIT OR ANY THIRD PARTY SETTLEMENT IN CONNECTION WITH THIS INJURY? ☐ YES ☐ NO

PHYSICIAN'S NAME _____ STREET ADDRESS _____ CITY AND STATE _____

DATE FIRST TREATED _____ ON WHAT DATE DID YOU OR DO YOU EXPECT TO RETURN TO WORK? _____ NAME AND ADDRESS OF YOUR EMPLOYER _____

DATE OF BIRTH _____ MARITAL STATUS _____ DO YOU OR YOUR SPOUSE HAVE ANY OTHER GROUP INSURANCE COVERAGE OR MEDICARE? ☐ YES ☐ NO _____ NAME OF OTHER INSURANCE COMPANY _____ POLICY OR GROUP No. _____

The above answers are true and complete according to the best of my knowledge and belief. I authorize the release to **Teamsters Local 641 Welfare Fund** of any additional medical information that may be required to establish the validity of this claim and further empower said Company to disclose any claim information needed for medical case review or study.

Date _____ _____ Signature of Employee _____

NOTE — Claim for Disability Benefits Must be Filed WITHIN 30 DAYS

EMPLOYER'S STATEMENT

NAME OF EMPLOYER _____ ADDRESS _____ ZIP CODE _____

LAST DATE EMPLOYEE WORKED _____ DATE EMPLOYEE RESUMED WORK _____ FULL OR PART TIME _____ IS THE CLAIM ONE WHICH MIGHT COME UNDER THE WORKMEN'S COMPENSATION OR UNEMPLOYMENT COMPENSATION ACTS? ☐ YES ☐ NO

I, OF MY PERSONAL KNOWLEDGE, KNOW THAT EMPLOYEE HAS LOST TIME AS REPORTED

Dated _____ Employer's Signature _____ Official Position _____ Phone Number _____

*AUTHORIZATION TO PAY HOSPITAL and/or DOCTOR

MUST be signed by employee (spouse's signature is NOT acceptable) if benefits are to paid to hospital or doctor, and name of payee entered.
I hereby authorize the Teamsters Local 641 Welfare Fund to pay the plan benefits directly to the doctors or hospitals named below:

Benefits to _____ **Benefits to** _____

Benefits to _____ **Benefits to** _____

Date _____ _____ **Signed** _____
Employee's Signature

HEALTH INSURANCE CLAIM FORM

Return to **Teamsters Local 641 Welfare Fund — IMMEDIATELY**

PATIENT INFORMATION — To be completed by employee

Patient's name and address	Patient's Date of Birth

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

SIGNED (EMPLOYEE'S SIGNATURE ONLY) ▶ DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT, OR PARENT IF MINOR) ▶ DATE

PHYSICIAN OR SUPPLIER INFORMATION — To be completed by provider of service

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBERS 1, 2, 3, ETC. IN COLUMN D)

1.
2.
3.

IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

☐ YES ☐ NO If YES, please explain

DATE		DATE FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
	ILLNESS..... DATE OF FIRST SYMPTOMS INJURY..... DATE OF ACCIDENT PREGNANCY..... DATE OF LMP		☐ YES ☐ NO

DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	DATES OF PATIENT'S DISABILITY ▶	TOTAL DISABILITY FROM DATE	TOTAL DISABILITY THROUGH DATE	PARTIAL DISABILITY FROM DATE	PARTIAL DISABILITY THROUGH DATE

NAME OF REFERRING PHYSICIAN	FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES	DATE ADMITTED	DATE DISCHARGED

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

A DATE OF EACH SERVICE	B PLACE OF SERVICE *See codes below	C DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES) — PROCEDURE CODE	C	D DX NO.	E CHARGES *(Explain unusual circumstances in Column C)*

PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.	SOCIAL SECURITY NO.	TOTAL CHARGES
	EMPLOYER I.D. NO.	AMOUNT PAID
If patient has other health insurance, please identify, indicate Group No.		BALANCE DUE

SIGNATURE OF PHYSICIAN OR SUPPLIER — SIGN HERE ▶ DATE SIGNED

F — FOR OFFICE USE ONLY

SHS _____
PO Days _____
Surg Code _____
Basic _____ X _____
R + C _____
NC _____
CONS. _____
___ visits @ $ _____
___ visits @ $ _____
DX _____
Vision _____
MM _____
Pay EE _____
Pay DR _____

1 — (IH)	INPATIENT HOSPITAL	4 — (H)	PATIENT'S HOME	7 — (NH)	NURSING HOME	O — (OL)	OTHER LOCATIONS
2 — (OH)	OUTPATIENT HOSPITAL	5 —	DAY CARE FACILITY (PSY)	8 — (SNF)	SKILLED NURSING FACILITY	A — (IL)	INDEPENDENT LABORATORY
3 — (O)	DOCTOR'S OFFICE	6 —	NIGHT CARE FACILITY (PSY)	9 —	AMBULANCE	B —	OTHER MEDICAL/SURGICAL FACILITY