

LOCALS 302 AND 612, INTERNATIONAL UNION OF OPERATING ENGINEERS CONSTRUCTION INDUSTRY HEALTH AND SECURITY FUND

EMPLOYEE STATEMENT									
<input type="checkbox"/> Check here if your address is new.									
PART 1 - EMPLOYEE INFORMATION									
EMPLOYEE'S NAME - First Initial Last			<input type="checkbox"/> M <input type="checkbox"/> F		EMPLOYEE SOCIAL SECURITY NUMBER			EMPLOYEE BIRTHDATE Mo. Day Year	
HOME ADDRESS		STREET		CITY		STATE		ZIP PHONE	
EMPLOYED BY								LOCAL NO.	
PATIENT'S NAME - First Initial Last			<input type="checkbox"/> M <input type="checkbox"/> F		PATIENT SOCIAL SEC. NO.		PATIENT BIRTH DATE Mo. Day Year		RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
EMPLOYEE MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL <input type="checkbox"/> SINGLE SEP. <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____				IF DEPENDENT CHILD IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF SCHOOL _____ IF "NO", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF SPOUSE (if not patient listed above)					SPOUSE BIRTHDATE		SPOUSE SOCIAL SECURITY NO.		
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME & ADDRESS SPOUSE'S EMPLOYER							
PART 2 - INSURANCE INFORMATION									
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO									
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER _____									
NAME OF SUBSCRIBER _____					SUBSCRIBER SOC. SEC. NO. _____				
OTHER GROUP PLAN COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN OTHER GROUP PLAN POLICY OR I.D.# _____									
OTHER GROUP PLAN INCLUDES: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION NAME OF PERSON COVERED _____									
ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES MEDICARE EFFECTIVE DATE _____									
PART 3 - ACCIDENT/INJURY INFORMATION									
WAS CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID ACCIDENT OCCUR WHILE AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO									
DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____									
HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE CLAIM NUMBER _____									
FOR TIME LOSS: LAST DAY WORKED _____ DATE RETURNED TO WORK _____									
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. Do not sign if bills have been paid.					I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original.				
Employee Signature _____ Date _____					Patient Signature (if not minor child) _____ Employee Signature _____ Date _____				
PROCEDURE FOR FILING A CLAIM									
1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim. 2. Attach an itemized bill for all charges relating to this claim. If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" on the reverse side of this form. 3. Complete a separate form for each patient. 4. Mail completed form and itemized bills to:									
OP ENGS LOC 302 & 612 H & S FUND P.O. BOX 34684 SEATTLE, WA 98124-1684 PHONE: (206) 441-7314 or 1-877-441-1212									
To insure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable. If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching insurance or Medicare payment explanation.									

