RETURN THIS FORM IMMEDIATELY TO:

OFFICE OF THE TRUSTEES
Local Union No. 710, Health and Welfare Fund
9000 W. 187th Street
Mokena, Illinois 60448

458

PROOF OF CLAIM
DISABILITY, HOSPITAL-SURGICAL-MEDICAL EXPENSE, MAJOR MEDICAL

PART 1– TO BE COMPLETED BY THE EMPLOYEE CLAIMING BENEFIT FOR SELF OR DEPENDENT

1. Name of Employee_____ Date of Birth_____
   FIRST MIDDLE LAST
2. Home Address_____ Sex____ Married____
   NO. and STREET CITY STATE ZIP
3. Check if this is a new address ☐
4. Employed by_____ Occupation_____
5. Claim is made for: ☐ Self
   (check one) ☐ Dependent _____
   NAME FIRST MIDDLE LAST RELATION SHIP DATE OF BIRTH SEX
6. Please list dependent's address if dependent does not currently reside with you.
   Home Address_____
   NO. and STREET CITY STATE ZIP CODE

TO BE ANSWERED IF CLAIMANT INJURED

7. Where did the injury occur?_____ Date and Hour_____
   How did the injury occur?_____
8. Was Employee or Dependent at work when the accident happened? ☐ YES ☐ NO

TO BE COMPLETED IN ALL CASES

9. I authorize any physician, and hospital, or any insurance company to disclose any knowledge or information acquired concerning this or other disabilities to The Health & Welfare Fund or its representative. I also authorize any physician or other person who has attended or examined me to disclose or testify to any knowledge or information this acquired, and I expressly waive on behalf of myself and of any person who shall have any interest in the insurance, all provisions of the law to the contrary. A photocopy of this authorization shall be as valid as the original.

DO YOU OR YOUR SPOUSE CARRY ANY GROUP INSURANCE THROUGH AN EMPLOYER (OR OTHERWISE) THAT WOULD COVER ANY OF THE BILLS INVOLVED IN THIS CLAIM? YES ☐ NO ☐

If yes, give the following information:

Name_____ Date of Birth_____ Social Security No._____

Address _____
STREET CITY STATE ZIP CODE PHONE NUMBER

Name of Employer _____

Insurance Carrier's Name_____ Policy No._____

Address of Insurance Company _____
STREET CITY STATE ZIP CODE PHONE NUMBER

Are any of the bills involved in this claim covered under Medicare? YES ☐ NO ☐

I hereby certify that the foregoing statement, including any accompanying statements, are true, correct and complete. I will reimburse the Fund for any adverse payments made to me or on my behalf due to any misrepresentation or error on this form.

NOTICE: Any misrepresentation or fraudulent statement by a claimant constitutes grounds for the denial of all benefits for the claimant or dependents, or the cancellation or recovery of benefit payments made in reliance thereon.

Date claim signed _____ Signature _____ Employee sign here

Phone No. _____ Social Security No. _____

THE REVERSE SIDE *MUST* BE *FULLY COMPLETED* BY THE *ATTENDING PHYSICIAN*

FORM 49810

PART 2 – TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Patient's name _____ Age _____
2. Date patient first treated for present disability _____
3. Is this disability the result of: ☐ Sickness ☐ Injury ☐ Pregnancy?
4. Diagnosis (describe nature of illness or injury and any complications) _____
   _____
5. Did illness or injury arise out of patient employment? YES ☐ NO ☐
6. Give dates of treatment: Office _____
   Hospital: (Name) _____
7. Nature of surgery or obstetrical procedures (describe fully) _____
   _____
   When performed? _____
   Where performed? _____ If in hospital: In-patient _____ Out-patient _____
8. Total Disability (unable to do any work)
   From _____ ____ through _____ ____.
9. If still disabled, when do you expect patient will be able to resume any work? _____
10. Is this person under your professional care or present? ☐Yes ☐ No. If no, Date discharged _____
11. Have you reported to any other insurance organization on this disability? YES ☐ NO ☐
    If Yes, please describe _____

Social Security or Tax Number _____ Signed _____ Degree

Date _____ ____ Address _____

_____ Phone _____

PRINT OR TYPE DOCTOR'S NAME

PART 3 – TO BE COMPLETED BY THE EMPLOYER IF THE EMPLOYEE IS ABSENT DUE TO ILLNESS OR INJURY

1. Name of Employer _____ Company Phone Number ( ) _____
2. Name of Employee _____ Occupation _____
3. Was Employee in your active fulltime employment when disability began? YES ☐ NO ☐
4. If Employee has terminated his employment, please give date of separation _____
5. Date _____ Signed _____ Title _____

If time loss is involved, Employer should certify:

6. Last day worked _____ Date resumed work _____ Date expected to resume work _____
7. Is this disability the result of occupational disease or injury arising in the course of employment _____
8. Is Employee currently receiving disability under Workmen's Compensation? YES ☐ NO ☐
   If so, please give us the date of disability _____