

ENGINEERS JOINT WELFARE FUND

101 Intrepid Lane • P.O. Box 100—Colvin Station • Syracuse, New York 13205-0100 • Phone (315) 492-1796



STATEMENT OF CLAIM TO BE COMPLETED BY MEMBER

Please Print All Answers

NOTE TO MEMBER: A claim for reimbursement for surgery or hospital expense must be supported by a certificate of the attending physician together with an itemized hospital statement. This section must be **COMPLETED** and **SIGNED** by member before any payment can be made.

1. Member's Name _____ Social Security Number _____
2. Address _____ Telephone No. _____
City _____ State _____ Zip _____
3. Date of Birth _____ Union Local No. _____
4. Spouses name _____ Birthdate _____
5. Marital status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Date of Divorce _____

INSURANCE INFORMATION (MUST COMPLETE)

6. Member: other Medical Insurance _____
Address _____
Contract or Policy Number _____ Dependents covered _____
7. Spouse or Unmarried Parent Medical Insurance _____
Address _____
Contract or Policy Number _____ Dependents covered _____
8. Stepchild's other Medical Insurance _____
Address _____
Contract or Policy Number _____

IF CLAIM IS FOR A DEPENDENT, FILL IN THIS SECTION

NOTE: If both parents have Health Insurance through their employer, claims on dependent children **MUST** be submitted first to the Insurance carrier of the parent whose birthday occurs earlier in the year (month & day only).

9. Dependent's Name _____ Date of Birth _____
10. Dependent's Social Security No. _____
11. Relationship: Spouse _____ Son _____ Daughter _____ Stepson _____ Stepdaughter _____

INSURED'S CERTIFICATION AND RELEASE: I hereby certify the statements hereon and attached are complete and accurate and I authorize any person or institution rendering care, or any other organization in possession of insurance or other benefit information concerning me or my dependents, to furnish and disclose all known facts, including clinical reports, charts, and X-rays concerning this claim.

12. Date _____ Member's Signature _____
(DO NOT PRINT)

ASSIGNMENT OF BENEFITS

13. In case a member should wish us to pay the PHYSICIAN or HOSPITAL direct, complete the following:
Doctor's Name _____ Hospital _____
Doctor's Name _____ Hospital _____
14. Member's Signature _____ Member's Signature _____

CERTIFICATE OF ATTENDING PHYSICIAN OR SURGEON

Please Fill in All Dates Carefully

1. I certify I attended NAME OF PATIENT Age Sex
2. Diagnosis (legible please)
3. In your opinion is disability due to any injury or illness arising out of patient's employment?
4. Was this injury due to an automobile accident?
5. Patient was hospitalized in hospital
From To
6. If surgery was performed by YOU, describe fully (legible please)
7. Date(s) surgery performed Where
CPT code(s) and charges
8. Any additional itemized charges
including dates and CPT codes
9. If surgery was not performed by you, give name and address of Surgeon:
10. If other services were performed, describe and include **itemized charges, dates and CPT codes**
11. If offering **SECOND** or **THIRD OPINION**, on surgery please indicate

TO YOUR KNOWLEDGE IS ANY OTHER INSURANCE AVAILABLE OR BEEN FILED		YES <input type="checkbox"/>		NO <input type="checkbox"/>	
MEDICAL LICENSE NO	TYPE OR PRINT DOCTOR'S NAME AND DEGREE				
TELEPHONE NO	ADDRESS (NUMBER AND STREET)				
DATE	(CITY)	(STATE)	(ZIP CODE)		
EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER					

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS APPLY TO THIS BILL AND ARE MADE A PART HEREOF).

SIGN HERE

X _____
SIGNATURE OF PHYSICIAN OR SUPPLIER

Billing information if different than above
