BAY AREA ROOFERS HEALTH & WELFARE TRUST FUND
United Administrative Services
P.O. Box 5057 San Jose, CA 95150

INSTRUCTIONS FOR FILING CLAIM
1. Employee complete this side of form.
2. Have attending physician complete the reverse side.
3. Attach itemized bills.
4. Send the completed form and bills to the address given

STATEMENT OF CLAIM
FOR
GROUP BENEFITS

TO BE COMPLETED BY INSURED EMPLOYEE

ANSWER ALL QUESTIONS THAT APPLY.
SIGN WHERE INDICATED BY ◄

EMPLOYEE IDENTIFICATION

Name _____ Marital Status _____
First Middle Last
SS No. _____ Date of Birth _____

Address _____
Street City State ZIP

DEPENDENT IDENTIFICATION (Complete only if claim Is for dependent)

Dependent's Name _____ Date of Birth

Relationship _____ Marital Status _____

EMPLOYMENT INFORMATION

Employer's Name **BAY AREA ROOFERS H&W TRUST**

Date Employed _____ Occupation _____

Do you have any other employer? ☐ Yes ☐ No If "Yes" complete below.

Name of Employer _____ Address of Employer _____

Is your spouse or any other of your dependents employed? ☐ Yes ☐ No If " Yes." complete below.
Dependent's Name Relationship Name and Address of Employer Spouse's Date of Birth _____

Are any hospital. surgical or medical benefits or services provided under any group. blanket, school. franchise or NoFault auto insurance plan, or under any state, federal or other governmental program? ☐Yes ☐No

Name and address of the insurance company or other organization providing benefits and the policy numbers

_____

Was the claimant covered under any group health plan in effect immediately prior to the date he or she became covered under the policy with no gap in coverage? ☐Yes ☐ No

If "Yes" please provide: (1) the name and address of the insurance company or other organization providing the benefits (2) the policy numbers; and (3) the date the claimant's coverage was effective.

Are you or your spouse or any child covered under Social Security (Medicare) Health Insurance? ☐ Yes ☐ No If " Yes," Indicate your coverage by checking appropriate box at the right.	**Hospital Only (PART A)**	**Medical Only (PART B)**	**Hospital and Medical**
	☐Self ☐Spouse ☐Child	☐Self ☐Spouse ☐Child	☐Self ☐Spouse ☐Child

CLAIM INFORMATION

Describe Sickness/Accident Suffered _____

Date Sickness Began/Date-Time of Accident

_____
MO DAY YR

Hour _____ ☐A.M. ☐P.M.

Was accident or sickness work related? ☐ Yes ☐ No

First day unable to work _____
Date Hour

Date returned to work _____
Date

If claim is for a dependent child over 18 years old. Is the child:
(a) dependent on you for support? ☐ Yes ☐ No
(b) a full-time student ☐ Yes ☐ No

(1) Give number of enrolled credit hours _____

(2) Name and address of school _____

_____

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading Information is guilty of a felony.

AUTHORIZATION TO RELEASE CLAIM INFORMATION
TO THE BAY AREA ROOFERS HEALTH & WELFARE TRUST FUND

To Any: Physician, hospital, pharmacist or other provider of health care services; insurer; employer; group policyholder; government agency; consumer reporting agency; acquaintance policy or benefit plan administrator:

You may give the Bay Area Roofers Health & Welfare Trust Fund information about _____ health, work status or health coverage.
Claimant's Name

You may also give this information on the Bay Area Rooters Health & Welfare Trust Fund's behalf to: (a) the claim investigation department of a consumer reporting agency; or (b) the claim department of a policy or benefit plan administrator. Health Information means all information about (a) a physical or mental health condition: (b) medical treatment and supplies: and (c) drug or alcohol use, if needed to evaluate my claim

This information will be used to evaluate my claim for benefits. This form will be valid for the duration of my claim. A photocopy of this form is as valid as the original I Will receive a copy of this form if I ask for one m writing.

Date _____ Signature of Claimant (if not a minor _____ ◄

Date _____ Signature Insured _____ ◄

Employer BAY AREA ROOFERS H&W TRUST

Opposite side is for attending physician' s statement.

TRUST FUND USE ONLY: Cert. No. _____ Class _____ Eff. date employee _____ Eff. date dep. _____ Term date _____