

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 Date of Birth

SS No. _____

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**

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 _____

Date Employed _____ Occupation _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Only (PART A)	Medical Only (PART B)	Hospital and Medical
	<input type="checkbox"/> Self	<input type="checkbox"/> Self	<input type="checkbox"/> Self
	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
If "Yes," Indicate your coverage by checking appropriate box at the right.	<input type="checkbox"/> Child	<input type="checkbox"/> Child	<input type="checkbox"/> Child

CLAIM INFORMATION

Describe Sickness/Accident Suffered _____

Date Sickness Began/Date-Time of Accident _____ <small>MO DAY YR</small>	Was accident or sickness work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	If claim is for a dependent child over 18 years old. Is the child: (a) dependent on you for support? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) a full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No (1) Give number of enrolled credit hours _____ (2) Name and address of school _____
Hour _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Firstday unable to work _____ <small>Date Hour</small>	
	Date returned to work _____ <small>Date</small>	

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.

You may also give this information on the Bay Area Roofers 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 in 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 _____