# BUILDING TRADES HEALTH AND WELFARE FUND

1718 HEILMANDALE ROAD, SUITE 400
LEBANON, PA 17046
TELEPHONE 273-3800

## CLAIMANT'S APPLICATION FOR BENEFITS UNDER GROUP POLICY

IMPORTANT — This form to be filled out by the **insured** and **doctor** immediately after the commencement of disability, or hospitalization.

Name and Address of Insured Employee _____ Date of Birth _____

Name and Address of Employer _____ Local No. _____

Description of employee's duties _____

### TO BE COMPLETED WHEN CLAIMANT IS NOT THE EMPLOYEE

Name and Address of Claimant _____

Relationship to Employee _____ Sex _____ Date of Birth _____

Attending Full-time School/College ☐ Yes ☐ No Where? _____ Graduation Date _____

### TO BE COMPLETED FOR ALL CHARGES SUBMITTED

1. Date sickness or accident occurred _____ Ceased Work on _____ at _____ AM PM

2. Was injury due to auto accident? ☐ Yes ☐ No

3. Did accident occur while at work? ☐ Yes ☐ No
   If "yes" explain.

4. Name of sickness or nature of injury _____

5. If injured, please explain in detail _____

6. Name of Doctor _____

7. Are you or your spouse insured under any other Group, Franchise, Blue Cross, Blue Shield, or other Service or Pre-payment Plan?
   ☐ Yes ☐ No
   If yes, is plan
   ☐ Sponsored by your employer
   ☐ Sponsored by your spouse's employer
   ☐ Direct Pay
   ☐ Medicare
   ☐ Part A
   ☐ Part B

   Name of spouse's employer _____
   Address _____
   Type of Plan _____
   Name of Insurance Co. _____
   Address _____

DATE _____ Insured's Signature: X _____

I hereby authorize any hospital, physician, or other person who has attended or examined me, or my dependent, to furnish to the BUILDING TRADES HEALTH AND WELFARE FUND any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Insured Sign Here X _____
Insured (Parent if Minor) Date

Approved by _____ M.D.

_____
Street Address City or Town State Zip Code

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Sign _____
(Insured Person)

## ATTENDING PHYSICIAN'S STATEMENT
## (GROUP INSURANCE)

(1) Patient's name _____ Age _____

(2) Nature of sickness or injury (Describe complications, if any) _____

_____

(3) Did this sickness of injury arise out of patient's employment? Yes _____ No _____

If "Yes," explain _____

_____

Is disability due to pregnancy? Yes _____ No _____

If "Yes," what was approximate date of commencement of pregnancy? _____ 20____

(4) Nature of surgical or obstetrical procedure and procedure code, if any (Describe fully) _____

_____

_____

(5) Date performed _____ 20____

Charge for this procedure $_____

Where performed _____ If in hospital, in-patient _____ out-patient _____

(6) Give dates of treatments and fees charged:

| Date Treated | Treated at (✓) Home | Hospital | Office | Fee Charged |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

(7) What other services, if any, did you provide patient? (Itemize, giving dates and fees) _____

_____

_____

(8) Is all or part of the above treatment rendered or operative procedures performed by you to be paid to you by any other employer sponsored group, franchise, Blue Shield, or any other service or prepayment plan? ☐ Yes ☐ No

If yes, state: Type of Plan _____ Amount $_____

## COMPLETE ONLY IF DISABLED

(9) The patient has been continuously disabled (unable to work) from _____ 20____ through _____ 20____

If still disabled, when should patient be able to return to work? _____ 20____

(10) Remarks: _____

_____

Date _____ 20____

Signed _____ M.D.
(Attending Physician)

Address _____

_____

Phone _____