U.A. PLUMBERS
LOCAL UNION #68

CLAIM FORM *GROUP INSURANCE*

Mail completed form to:
U. A. Plumbers Local Union #68
Group Protection Plan
P.O. Box 8726
Houston, Texas 77249
(713) 869.2592 Fax # 713-862-4877

TO BE COMPLETED BY EMPLOYEE ♦ ANSWER ALL QUESTIONS THAT APPLY ♦ SIGN WHERE INDICATED BY (⊠)

EMPLOYEE NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH	SOCIAL SECURITY NO.
COMPLETE HOME ADDRESS	CITY	ZIP	TELEPHONE NO.
EMAIL ADDRESS	CELL NUMBER	☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	
CLAIM IS MADE FOR ☐ SELF ☐ SPOUSE ☐ CHILD	NAME OF CLAIMANT	☐ MALE ☐ FEMALE	DATE OF BIRTH

DEPENDENT SECTION

Age 19 to 26: Provide College enrollment of at least 12 credit hours per semester or;
Complete annual Dependent Enrollment form.

SPOUSE SECTION *(MUST BE COMPLETED IN ALL CASES)*

Name:		Social Security No.

Has your spouse been employed in the past twelve months: ☐ Yes ☐ No

Employer:		Address:

DO YOU, YOUR SPOUSE, OR CHILD HAVE OTHER INSURANCE (OTHER THAN THE UA PLUMBERS UNION #68) OF THE TYPES DESCRIBED BELOW?

A.	Group Insurance, or any other arrangement of coverage for individuals in a group?	☐ Yes ☐ No	B.	Any coverage for dependents?	☐ Yes ☐ No

GIVE NAME, ADDRESS AND PHONE NUMBER OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS/SERVICES FOR __SELF__SPOUSE__CHILD

INSURED:	NAME & ADDRESS OF INSURANCE / ORGANIZATION	PHONE NUMBER	POLICY NO. OR IDENTIFICATION NO.

INJURY SECTION:

DATE OF ACCIDENT:		Time	☐ AM ☐ PM	DETAILS OF ACCIDENT
WAS CLAIMANT AT WORK WHEN THE ACCIDENT OCCURRED?	☐ Yes ☐ No			
WAS DISABILITY CAUSED BY WORK RELATED ACCIDENT?	☐ Yes ☐ No	HAVE YOU FILED A CLAIM WITH WORKERS' COMPENSATION FOR THIS DISABILITY?	☐ Yes ☐ No	FIRST DATE UNABLE TO WORK / DATE RETURNED TO WORK

I / WE jointly certify that the above information is true and correct. I / WE hereby authorize all doctors, dentists, psychologists, pharmacists, hospital or other institutions providing care, treatment, consultation, drugs, or supplies to furnish U.A. Plumbers LU #68 Group Protection Plan with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered – including a copy of their records. I / WE authorize any insurance carrier, service plan, union, trust fund, or employer to furnish U.A. Plumbers LU #68 Group Protection Plan to release any information relevant to a determination of the applicability of an implementation of a coordination of benefits provision to any insurance carrier, service, plan, union, trust fund or employer requesting such information.

Date	Employee's Signature ⊠	Spouse's Signature ⊠

LU68-GROUP MEDICAL 05/04

By signing this I accept Plan coverage for Dental and Vision benefits, in addition to Medical benefits described in the Plan. I understand, that if for any reason I desire to not accept Dental and Vision benefits, I may contact the Fund Office to record my choice to not accept the Dental and Vision benefits of the Plan.

CLAIM FORM MUST BE FILLED OUT EVERY YEAR
FOR EACH ELIGIBILE MEMBER IN HOUSEHOLD
Email: benefits@plu68.com