RETURN FULLY COMPLETED FORM TO:

SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

1171 COMMERCE DRIVE, UNIT 1 WEST CHICAGO, ILLINOIS 60185-2680
TELEPHONE 630.293.5218 FAX 630.293.5845

INSTRUCTIONS: This Claim Form is to furnish the information needed to process your Claim. Please answer ALL questions fully.

MEMBER INFORMATION

Name of Member _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____ Telephone No. (____) _____

ID or Social Security # _____ Occupation _____ Active ☐ Retire Date _____

Marital Status: Single ____ Married ____ Divorced ____ Legally Separated ____ Widowed ____

***Note:** If recently married or divorced, indicate date(s) _____

OTHER INSURANCE INFORMATION

Do you **or** your dependents have **ANY** other health insurance? ☐ YES ☐ NO If YES please supply:

1) Name of the person insured _____ Relationship to Employee: _____

2) Insured person's Social Security No. _____ Date of Birth _____ Policy No. _____

3) Insurance company name _____ Telephone No. (____) _____

4) Address, City, State, Zip _____

5) Type of Policy. For example, Employer Sponsored, Individually Purchased, School Insurance, etc. _____

_____

SICKNESS/INJURY INFORMATION *Required for all claims*

This claim is for ☐ Self ☐ Spouse ☐ Dependent

Name of Patient _____ Social Sec. No. _____ Date of Birth _____

Patient's Occupation _____ _____

Name and Address of Employer or School _____

Claim is for ☐ an accident ☐ a sickness _____

Briefly describe nature of illness or injury (for example: heart, fall, etc.) _____

_____

Date accident occurred or sickness first began _____ Date first treated _____

If injured, detailed description of **HOW** and **WHERE** accident occurred _____

_____

_____

Did injury or sickness occur in the course of **ANY** employment? ☐ YES ☐ NO

Have you or do you intend to file a claim under Workers' Compensation? ☐ YES ☐ NO

MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative, of any facts and/or related records concerning the injury, illness, or treatment (including mental/nervous and substance abuse) for myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Member's Signature X _____ Date _____

IMPORTANT:

HAVE YOU SIGNED THIS FORM AND ANSWERED ALL QUESTIONS?