

OPEIU LOCALS 30 & 537 HEALTH AND WELFARE FUND



Send Completed Form to:

OPEIU Locals 30 & 537 Claims Office
 13191 Crossroads Parkway North, Suite 205
 City of Industry, CA 91746-3434
 Telephone: (562) 463-5065
 (800) 386-4350

IMPORTANT! READ CAREFULLY

Part 1 — Employee completes in all cases.

Part 2 — Attending physician or surgeon completes.

Attach itemized bills except those for services shown in "Attending Physician's Statement" in Part 2 on the reverse side of this form.

PART 1

EMPLOYEE COMPLETES IN ALL CASES

CLAIM FORM MUST BE RETURNED WITHIN 90 DAYS

1. Employee's Name (Please Print)		Date of Birth	Social Security No.
2. Home Address — No. and Street		City	State Zip Code Telephone No.
3. Employed By		If over 65, check one: <input type="checkbox"/> Active <input type="checkbox"/> Retired	
4. Name of your spouse		Date of Birth	Social Security No.
5. Name and Address of Spouse's Employer			
5a. Is this the first Local 30 Health and Welfare Fund Claim for this Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Claim is Made For	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Name of Patient	<input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth
7. WAS PATIENT'S INJURY INCURRED ON THE JOB OR THE ILLNESS CAUSED BY THE PATIENT'S WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Is person for whom claim is made covered by other group health insurance policy or health service plan <input type="checkbox"/> Yes <input type="checkbox"/> No			
A. Is claim for auto accident? If so, please complete auto insurance information.			
If Yes, give name of companies			
If "Yes", give address of claims paying offices of other insurance companies			
Group Policy Numbers			
Group Contract Numbers Certificate Number			
9. TO BE COMPLETED IF YOU OR YOUR DEPENDENT INJURED			
Date of Accident	Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Where?	Was Patient at Work When Accident Happened? <input type="checkbox"/> Yes <input type="checkbox"/> No If So, For Whom
How Did Accident Happen?			
RELEASE OF INFORMATION			
I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish OPEIU LOCAL 30 HEALTH AND WELFARE FUND with full information regarding treatment rendered (including copies of their records). I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish OPEIU LOCAL 30 HEALTH AND WELFARE FUND with information regarding benefits to which I/We may be entitled. (If claim for spouse, spouse also must sign.)			
Date	Dependents Signature	Employees Signature	

ADMINISTRATOR'S STATEMENT

Effective date of employee's insurance, 19

Effective date of dependent's insurance, 19

VERIFIED	VERIFIED	VERIFIED	VERIFIED
Jan	Apr	Jul	Oct
Feb	May	Aug	Nov
Mar	Jun	Sep	Dec

