# OPEIU LOCALS 30 & 537 HEALTH AND WELFARE FUND

Send Completed Form to:

**OPEIU Locals 30 & 537 Claims Office**
1200 Wilshire Blvd, 5th Floor
Los Angeles, CA 90017-1906
**Telephone: (562) 463-5065 (800) 386-4350**

## EMPLOYEE COMPLETES IN ALL CASES

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: ☐ Active ☐ 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 Locals 30 & 537 Health and Welfare Fund Claim for this Patient? ☐ Yes ☐ No

| 6. Claim is Made For | | Name of Patient | | Date of Birth |
|---|---|---|---|---|
| | ☐ Self | | ☐ Male | |
| | ☐ Spouse | | ☐ Female | |
| | ☐ Child | | | |

7. WAS PATIENT'S INJURY INCURRED ON THE JOB OR THE ILLNESS CAUSED BY THE PATIENT'S WORK? ☐ Yes ☐ No

8. Is person for whom claim is made covered by other group health insurance policy or health service plan? ☐ Yes ☐ 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 WAS INJURED**

| Date of Accident | Time | | Where? | Was Patient at Work When Accident Happened? ☐ Yes ☐ No If So, For Whom |
|---|---|---|---|---|
| | _____ | ☐ A.M. ☐ P.M. | | |

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 LOCALS 30 & 537 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 LOCALS 30 & 537 HEALTH AND WELFARE FUND** with information regarding benefits to which I/We may be entitled. (If claim for spouse, spouse must also sign.)

Date | Dependent's Signature | Employee's Signature

**EMPLOYEE'S ASSIGNMENT**
**(Read before signing)**

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS IS DESIRED
(This assignment may not be honored if signed by a dependent or person other than the employee.)

I hereby assign Benefits indicated hereon, to the extent of their interest established herein or by statements attached.

DATED ..... SIGNED .....
(SIGNATURE OF INSURED EMPLOYEE)