

# 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**

## 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: <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 Locals 30 & 537 Health and Welfare Fund Claim for this Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Claim is Made For		Name of Patient	Date of Birth
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	
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 .....			
<b>9. TO BE COMPLETED IF YOU OR YOUR DEPENDENT WAS INJURED</b>			
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?			
<b>RELEASE OF INFORMATION</b>			
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 <b>OPEIU LOCALS 30 &amp; 537 HEALTH AND WELFARE FUND</b> 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 <b>OPEIU LOCALS 30 &amp; 537 HEALTH AND WELFARE FUND</b> 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	
<b>EMPLOYEE'S ASSIGNMENT</b>			
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.)			
(Read before signing) I hereby assign Benefits indicated hereon, to the extent of their interest established herein or by statements attached.			
DATED ..... SIGNED .....			
(SIGNATURE OF INSURED EMPLOYEE)			