



COMPLETE AND RETURN TO:

PLUMBERS AND STEAMFITTERS LOCAL UNION #43

2187 Northlake Parkway, Suite 106, Building 9

Tucker (Atlanta), Georgia 30084



STATEMENT OF CLAIM

HOW TO FILE A CLAIM

- 1. Have attending physician complete reverse side of form and return to you.
2. Employee complete this side of form.
3. Attach itemized bills.
4. Forward completed bills to address shown above.
5. File claims promptly.

TO BE COMPLETED BY THE EMPLOYEE

- 1. Name of Group or Welfare Fund Local Union No.
2. Member's Name Telephone No.
3. Address (Street) (City) (State) (Zip)
4. Social Security Number Birth Date Birth Date of Spouse
5. Are You: Single Married Separated Divorced Retired
If You Are Divorced and Claim Is For Dependent Child, Who Has Custody Of Child?
Is There a Court Order For The Child's Medical Expenses? Yes No
If Yes, Please Give the Name of the Person With This Financial Responsibility
6. If Claim for Dependent, Give Name Dependent's Birth Date
Relationship of Dependent to Employee
7. Date of Treatment for Sickness Date Last Worked
8. List Name of Employer For Whom You Last Worked
9. If Accident, When, Where and How Did Accident Happen? (When) (Where) (How)
Did Injury Occur in Course of Any Employment? Yes No
Will You File Claim Under Workman's Compensation? Unemployment Insurance?
On What Date Did You, or Do You Expect To Return To Work?
10. Are You, Your Spouse or Child Insured Under Any Other Group Insurance Plan? Yes No
If Yes, List Name and Address of Other Group Insurance Carrier. Give Group and/or Policy Number

If other group insurance benefits have been paid, please furnish a copy of the payment statement from other Carrier. In the event that you have not filed for benefits with the other Carrier, you should file at once and advise us as to the benefits allowed.

I hereby agree to reimburse Plumbers and Steamfitters Local Union #43 Welfare Fund to the extent of any overpayment which is in excess of the amounts payable under this group policy, and I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information by me in support of this claim is true and correct to the best of my knowledge.

DATE SIGNATURE OF EMPLOYEE

SIGNATURE OF OTHER FAMILY MEMBER WHOSE INSURANCE COVERS THIS INDIVIDUAL