STATEMENT OF CLAIM FOR MEDICAL BENEFITS

Benefits of this plan are self-funded. Help control costs. Every dollar spent or saved directly affects each covered person. Attach itemized bill or have the provider submit the charges.

RETURN COMPLETED CLAIM FORM TO:

EMPLOYERS AND OPERATING ENGINEERS LOCAL 520
Health and Welfare Fund
Eight Executive Woods Court
Swansea, Illinois 62226
(618) 233-7978 Fax (618) 233-7716

MEMBER COMPLETES THIS STATEMENT OF CLAIM

Print or type answers to all questions.

1. **Member** _____ **SS#** _____ **Member Marital Status** _____

2. **Patient** _____ **Date of Birth** _____ **Is patient on Medicare? Yes** _____ **No** _____
   Address where patient lives _____

3. **Is patient a dependent? Yes** _____ **No** _____ **Relationship** _____ Telephone Number _____
   Full Time Student? Yes _____ **No** _____ **Name of School** _____

4. **Is the patient's ailment due to injury arising out of or in the course of employment ? Yes** _____ **No** _____
   If yes, give details. _____

5. **Is claim due to accident? Yes** _____ **No** _____ **Date** _____ **Where** _____
   How _____ **Was Auto Involved? Yes** _____ **No** _____

6. **Is claim due to sickness ? (give details) date of first symptoms, diagnosis, etc.** _____
   _____

7. **If Local 520 member is married, is spouse employed? Yes** _____ **No** _____
   First name of Spouse _____ **Employer** _____
   Address of employer _____

8. **Is patient covered by any other insurance benefits for this service?** Insured Name _____
   (Group Insurance, Medicare, Auto no-fault, Liability Coverage or Medicaid)
   Yes _____ **No** _____ **If Yes: Plan Name** _____ **Plan Number** _____
   Claim Office Address _____ **Telephone Number** _____
   City, State, Zip _____
   (Please note: If patient is covered by 2 separate Healthlink Plans, you must advise the Fund Office by answering Yes to # 8)

Authorization to Pay Benefits to Physician or Provider: I hereby authorize payment directly to the provider, but not to exceed the reasonable and customary charge for the services.
Signed (Member) _____ **Date** _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my Employer, Union, Employers and Operating Engineers Local 520 Health and Welfare Fund, Providers, or other companies or organizations providing benefits or services for medical treatment or supplies to release or obtain any information necessary to determine the benefits payable under the Employers and Operating Engineers Local 520 Health and Welfare Fund. I certify this employee statement is correct and complete to the best of my knowledge.
Signed (Patient or Parent) _____ **Date** _____

SUBROGATION AND REIMBURSEMENT AGREEMENT

In accordance with the Reimbursement (Subrogation) provision of the Welfare Benefit Plan provided by Employers & Operating Engineers Local 520 Health and Welfare Fund, I agree to reimburse and pay promptly to said Fund an amount not exceeding the aggregate amount of benefits paid or to be paid to me on my behalf under the Welfare Fund as a result or injury or disease sustained on or about _____ **in** _____ **County, State of** _____**, out of any recovery by settlement, judgment or otherwise, from any responsible person or their insurance or any other source of payment. I further agree to execute instruments and papers, furnish information and assistance, and take other necessary and related action as may be required to facilitate the Employers & Operating Engineers Local 520 Health and Welfare Fund's right of reimbursement (Subrogation) under the Welfare Fund. I understand that I have not released or discharged my rights of recovery described herein and that I have done nothing to prejudice these rights.**

_____

Dependent Signature

Member Signature

Rev 6/99