

WEEKLY BENEFITS (COMPANY STATEMENT ON BACK MUST BE COMPLETED)

PATIENT INFORMATION (TO BE COMPLETED BY MEMBER)

1 PATIENT'S NAME (First name, middle initial, last name)		2A PATIENT'S DATE OF BIRTH	2B PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3 MEMBER'S NAME (First name, middle initial, last name)	
4 PATIENT'S ADDRESS (Street, city, state, zip code)		5 MEMBER'S EMPLOYER		6 MEMBER'S SOCIAL SECURITY NO	
		7 PATIENT'S RELATIONSHIP TO INSURED (CIRCLE ONE) SELF SPOUSE CHILD OTHER		8 MEMBER'S LOCAL NO RETIRED YES <input type="checkbox"/> NO <input type="checkbox"/>	
9 IS PATIENT FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		10 WAS CONDITION RELATED TO		11 MEMBER'S ADDRESS (Street, city, state, zip code)	
SCHOOL _____ IS PATIENT EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/> EMPLOYER _____ PHONE _____		A PATIENT'S EMPLOY YES <input type="checkbox"/> NO <input type="checkbox"/> B AN ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES to either of the above questions give DATE _____ 19__ TIME _____ DESCRIPTION HOW WHERE			
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>1 Authorize the Release of any Medical Information Necessary to Process this Claim</i> SIGNED _____ DATE _____		13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW SIGNED (Insured or Authorized Person) _____			

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

14 DATE OF		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION		16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
17 DATE PATIENT ABLE TO RETURN TO WORK			18 DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		IN YOUR OPINION WAS THE DISABILITY DUE TO OCCUPATIONAL SICKNESS OR ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
19 NAME OF REFERRING PHYSICIAN			20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____			
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO charges _____			
23 ICD9-CM CODE		23A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 OR DX CODE				
1 _____		1 _____				
2 _____		2 _____				
2 _____		3 _____				
24 A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURE MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE* (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*		D DIAGNOSIS CODE	E CHARGES	F
25 YOUR PATIENT'S ACCOUNT NO				26 TOTAL CHARGE	27 AMOUNT PAID	28 BALANCE DUE
29 SIGNATURE OF PHYSICIAN OR SUPPLIER		DATE	SOCIAL SECURITY NO	ADDRESS		
30 COMPLETE THE FOLLOWING AS IT SHOULD APPEAR FOR TAX PURPOSES:						
PHYSICIAN'S OR SUPPLIER'S NAME		TAXPAYER IDENTIFICATION NUMBER (1099 REPORTING PURPOSES)		ADDRESS		
				PHONE		

*PLACE OF SERVICE CODES
 1 - (IH) - INPATIENT HOSPITAL
 2 - (HO) - OUTPATIENT HOSPITAL
 3 - (O) - DOCTOR'S OFFICE

4 - (H) - PATIENT'S HOME
 5 - (PSY) - DAY CARE FACILITY
 6 - (PSY) - NIGHT CARE FACILITY

7 - (NH) - NURSING HOME
 8 - (SNF) - SKILLED NURSING FAC.
 9 - (AMB) - AMBULANCE

0 - (OL) - OTHER LOCATIONS
 A - (IL) - INDEPENDENT LABORATORY
 B - (M) - OTHER MEDICAL/SURGICAL FACILITY



COMPANY STATEMENT:
(TO BE COMPLETED BY
EMPLOYER ONLY)

Complete this section along with the information on reverse side of the form, only if you are applying for Weekly Disability benefits (Loss of Time). Do not attach Physician bills to a Weekly benefit claim, it will result in a delay of payment of your Weekly benefits.

1. Employee's Name _____	2. Date Employed _____
3. Employee's Occupation _____	
4. Date Employee Last Worked _____ / _____ / _____	Time of Day _____
Reason for Stopping Work _____	
5. Is any of this time after employee last worked Paid Vacation? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, specify dates _____	
Is any of this time after employee last worked Paid Sick Time? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, specify dates _____	
6. Date Employee Returned to Work _____ / _____ / _____	
7. Is this Accident or Sickness Due to Employment? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, has Employee applied for Workman's Compensation? _____	
8. Prior to this Disability was the Employee <input type="checkbox"/> Laid Off <input type="checkbox"/> On Leave <input type="checkbox"/> Retired <input type="checkbox"/> Discharged	
Company name & address _____	
Date _____	Signed by _____
Phone No. _____	Extension _____

"QUICK PAYMENT" INSTRUCTIONS

1. YOU MUST USE A SEPARATE CLAIM FORM FOR EACH DIFFERENT TYPE CLAIM. FOR EXAMPLE — IF YOU ARE SUBMITTING A HOSPITAL CLAIM, PHYSICIAN CLAIM AND A WEEKLY BENEFIT CLAIM, YOU MUST COMPLETE 3 OF THESE CLAIM FORMS.
2. COMPLETE THE "PATIENT AND MEMBER (INSURED INFORMATION" ITEMS 1 THROUGH 12) ON THE REVERSE SIDE OF THIS FORM.

If you wish your medical benefits paid directly to your doctor, sign item 13. A separate form should be submitted for each family member.
3. HAVE YOUR DOCTOR COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" (ITEMS 14 THROUGH 30) OR SUBMIT COMPLETELY ITEMIZED BILLS. NOTE — IF PAYMENT IS BEING MADE TO THE MEMBER, AN ITEMIZED BILL MUST BE ATTACHED TO EACH CLAIM.

An itemized bill is one that shows the patient's name, date of service, the type of service, the charge for each type of service and the nature of the condition being treated.
4. PLEASE FURNISH FULL AND COMPLETE DETAILS, IF ANY REQUIRED INFORMATION IS NOT GIVEN IT WILL BE NECESSARY TO RETURN THE FORM FOR COMPLETION BEFORE THE CLAIM CAN BE PROCESSED.

NOTE: This form is not to be used to obtain Vision or Dental Benefits.

FOR DOCTOR/HOSPITAL

For your convenience, the Fund will accept computer generated invoices that contain essentially the information requested on this claim form. To maintain control, dated signatures for release of medical information and authorization of payment must be attached to the computer generated form and the computer should print signature attached in the appropriate spaces

Do not attach Physician bills when providing information on a weekly disability claim (Loss of time benefits)