

RETURN completed claim form to:

PLUMBERS & PIPEFITTERS LOCAL NO. 520 HEALTH AND WELFARE FUND

P.O. BOX 6480 • HARRISBURG, PA 17112-0480

D.H. EVANS ASSOCIATES, INC. • Contract Administrator • (717) 671-8551

(EMPLOYEE MUST COMPLETE THIS PORTION OR CLAIM CANNOT BE PAID!)

Name of Employee _____ Date of Birth _____ Soc. Sec. No. _____

Home Address _____ Badge No. _____

Employer's Name and Address _____ Date Employed _____

For Employee's Disability, Show Date Last Worked _____ Date Resumed Work _____

Complete If Claim Is For Dependent	Name of Dependent		Relationship to Employee	Date of Birth
		Is Dependent Employed? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, State Where:
	or A college student? Yes <input type="checkbox"/> No <input type="checkbox"/>			
F O R A L L C L A I M S	Nature of sickness or injury _____			
	Date of accident or sickness _____		Date First Treated _____	
	Name and Address of (1) _____			
	Physicians Consulted (2) _____			
	If hospitalized Name of hospital _____ Admitted _____ Date _____ Discharged _____ Date _____			
	If injured, how and where did accident happen? _____			
	Did injury occur in the course of any employment? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Have you, or do you intend to file this claim under Workmen's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Will this claim for benefits be made under any other policy or with any other company? . . . Yes <input type="checkbox"/> No <input type="checkbox"/>			
	(Individual, Group, Blue Cross, Student Accident, etc.) If YES, give Company name _____			

NOTE: FOR EMPLOYEE DISABILITY CLAIM - TO BE COMPLETED BY EMPLOYER

Date Last Worked _____	Date Work Resumed _____	Might claim be covered by Workmen's Compensation Law? Yes <input type="checkbox"/> No <input type="checkbox"/>
Employee's Current Status: Active <input type="checkbox"/> Terminated <input type="checkbox"/>	Leave of Absence <input type="checkbox"/>	Temporary Lay Off <input type="checkbox"/>
Date _____	Signature _____	Official Position _____

EMPLOYEE'S AND PATIENT'S SIGNATURES

The undersigned assigns to the Fund any amount received from any party, in any action at law, compromise, settlement, or agreement to the extent of the Fund's benefits paid for the undersigned which are for reimbursable causes in accordance with the rules of the Fund.

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Plumbers & Pipefitters No. 520 Health and Welfare Fund, of any facts concerning the injury, illness, or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original. This release is valid until revoked by me in writing.

(Signed) _____ (Employee) (Signed) _____ (Patient)

Dated _____ (Street Address) (City or Town)



ATTENDING PHYSICIAN'S STATEMENT

NOTE: Doctor — Please enter YOUR employee ID number or Social Security number below

Patient's Name and Address _____ Age _____

Insured's Name If Patient is a Dependent _____

Diagnosis and Concurrent Conditions			
Is Condition Due To Injury or Sickness Arising Out of Patient's Employment?	If "Yes" Explain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is Condition Due to Pregnancy?	If "Yes" What Was Approximate Date of Commencement of Pregnancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/> Date _____
When Did Symptoms First Appear or Accident Happen?	Date _____		
When Did Patient First Consult You For This Condition?	Date _____		
Has Patient Ever Had Same Or Similar Condition?	If "Yes" State When and Describe	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nature of Surgical or Obstetrical Procedure, If any (Describe Fully)	Date Performed _____		
Charge to Patient For This Procedure Including Post-Operative Care	\$ _____		
If Performed in Hospital, Give Name of Hospital			Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/>
Give Dates of Other Medical (Non-Surgical) Treatment, If Any			Charge Per Call
	Office	\$ _____	
	Home	\$ _____	
	Hospital	\$ _____	
	Total (Non-Surgical) Charges \$ _____		
What Other Services, If Any, Did You Provide Patient? (Itemize, Giving Dates and Fees)			
Is Patient Still Under Your Care For This Condition? If "No" Give Date Your Services Terminated	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date _____
How Long Was or Will Patient be Continuously Totally Disabled (Unable to Work)?	From _____ Thru _____		
To Your Knowledge Does Patient Have Other Health Insurance or Health Plan Coverage? If "Yes" Identify	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Date _____ Print or type name of Attending Physician _____ Degree _____ Tax I.D. or Soc. Sec. No. _____ Telephone _____

Street Address _____ City of Town _____ State _____ Zip Code _____

(Signature of Attending Physician)

Claimant's Assignment (Read before signing)

To be completed and signed by the Claimant if direct payment by Fund to surgeon or physician is desired. (This assignment WILL NOT be honored if signed by a dependent or a person other than the claimant.)
Date _____

I hereby authorize the Plumbers & Pipefitters Local 520 Health and Welfare Fund to pay directly to the above named physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Benefits to the extent of his interest as established herein.

(Signature of Insured Union Member)