

ILWU-PMA WELFARE PLAN

CLAIM FORM FOR HOSPITAL, MEDICAL, SURGICAL BENEFITS

Fill out Part 1
Have your doctor complete Part 2
For Hospital Benefits attach itemized bill

PART 1 - EMPLOYEE STATEMENT

1. NAME OF EMPLOYEE		2. LOCAL NUMBER	3. REGISTRATION NUMBER	4. SOCIAL SECURITY NUMBER	5. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/>
6. ADDRESS (STREET)		(CITY)	(STATE)	(ZIP)	
7. NAME OF PATIENT IF NOT EMPLOYEE				8. PATIENT'S DATE OF BIRTH / /	
9. PATIENT'S RELATIONSHIP TO EMPLOYEE	10. IF CHILD INDICATE: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	11. IF MARRIED, IS SPOUSE EMPLOYED YES <input type="checkbox"/> NO <input type="checkbox"/>		12. IF YES, SPOUSE'S SOCIAL SECURITY NO.	
13. SPOUSE'S EMPLOYER			ADDRESS (STREET, CITY, STATE, ZIP CODE)		
15. IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE OR HEALTH SERVICE PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>		16. IF YES, POLICY NUMBER		17. NAME OF OTHER PLAN	
18. ADDRESS OF OTHER PLAN (STREET, CITY, STATE, ZIP CODE)					
19. Do you have Medicare Insurance? (Part A - <input type="checkbox"/> YES <input type="checkbox"/> NO) (Part B - <input type="checkbox"/> YES <input type="checkbox"/> NO) Effective Date: / /			20. Does your spouse or any of your children have Medicare Insurance? (Part A - <input type="checkbox"/> YES <input type="checkbox"/> NO) (Part B - <input type="checkbox"/> YES <input type="checkbox"/> NO) Name: _____ Effective Date: / /		
21. IS PATIENT'S CONDITION DUE TO AN ACCIDENT, INJURY, OR ILLNESS ARISING OUT OF EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			22. IF ANSWER TO 21. IS YES, HAVE YOU OR THE PATIENT FILED, OR DO YOU INTEND TO FILE, A CLAIM FOR BENEFITS UNDER ANY FEDERAL OR STATE WORKER'S COMPENSATION LAW? YES <input type="checkbox"/> NO <input type="checkbox"/>		
23. IS PATIENT'S CONDITION DUE TO AN ACCIDENT, INJURY, OR ILLNESS CAUSED BY SOME OTHER PARTY? YES <input type="checkbox"/> NO <input type="checkbox"/>			24. IF ANSWER TO 23. IS YES, HAVE YOU OR THE PATIENT FILED, OR DO YOU INTEND TO FILE, ANY LEGAL ACTION OR CLAIM AGAINST THE OTHER PARTY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
25. IS PATIENT'S CONDITION DUE TO AN ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			26. IF ANSWER TO 25. IS YES, HOW, WHERE, AND DATE.		
<p>The above answers are true and complete to the best of my knowledge and belief, I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA Coastwise Claims Office as is required to properly pay all benefits due me or my dependents.</p> <p>DATE / / SIGNATURE _____ SIGNATURE OF EMPLOYEE</p>					
PAY TO PROVIDER — OPTIONAL					
IF YOU WANT BENEFITS PAID TO THE PROVIDER OF CARE, THIS SECTION MUST BE SIGNED BY THE EMPLOYEE.					
<p>Date / / Signed _____ SIGNATURE OF EMPLOYEE</p>					

PART 2 - PHYSICIAN STATEMENT

1. Patient's Full Name _____

2. Diagnosis _____

(a) Is patient's condition due to an accident? YES NO If YES, give date _____ / _____ / _____

(b) Is patient's condition due to an accident, injury or illness arising out of employment? YES NO

(c) Is patient's condition due to an accident, injury or illness caused by some other party? YES NO

3. Date patient first treated for present disability _____ / _____ / _____

4. Is treatment continuing? YES NO

5. Surgical procedures performed _____ Date _____ / _____ / _____
 _____ Date _____ / _____ / _____

6. Confined to _____ Hospital from _____ to _____
 (Name of Hospital)

7. Is patient disabled (unable to perform usual activities)? YES NO
 From _____ To _____

8. Please attach itemized Bill. In lieu of itemized Bill, itemize Charges below:

DATE AND PLACE			NATURE OF SERVICES <small>Examination, Treatment, Surgery, etc.</small>	CPT No.	YOUR CHARGE TO PATIENT
Home	Hospital	Office			
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

9. To your knowledge does patient have other Health Insurance or Health Service Plan Coverage? YES NO
 if YES, please identify _____

ATTENDING PHYSICIAN _____ M.D.
 (Please Print Name)

Address _____ Federal Tax No. _____
 No. Street

City _____ State _____ Zip _____ Telephone _____

Date _____ / _____ / _____ Signed _____

Mail Completed Form to:

ILWU-PMA COASTWISE CLAIMS OFFICE
 814 MISSION STREET, SUITE 300
 SAN FRANCISCO, CA 94103