ILWU-PMA WELFARE PLAN

CLAIM FORM FOR SUPPLEMENTAL HOSPITAL, MEDICAL, SURGICAL BENEFITS

For Retirees, Their Dependents or Survivors Enrolled Under Part A and Part B of Medicare

ILWU-PMA COASTWISE CLAIMS OFFICE

1. **IDENTIFICATION** EMPLOYEE'S NAME ______________________ ☐ Retired ☐ Survivor

Date of Birth ____________ Local No. ____________ Registration No. ____________

If claim is for Spouse, SPOUSE'S NAME ______________________

2. **EXPLANATION** Medicare will send you a record of the action taken on your Medicare claim -- A **Record of Hospital Benefits used under Medicare,** or an **Explanation of Benefits, Medical Insurance.** The Medicare notice(s) must be submitted with this claim.

TO COMPLETE THIS CLAIM, fill in Part 1. Sign the Authorization, Part 10. If you want payment made directly to the hospital or doctor, even when claim is for your spouse, complete and sign the Optional Assignment, Part 11.

3. Is the patient covered by any other Group Insurance or Health Service Plan? ☐ Yes ☐ NO

If yes, Policy No. ____________ . Name of other Plan ______________________

Address of other Plan ______________________

4. IS PATIENT'S CONDITION DUE TO AN ACCIDENT, INJURY, OR ILLNESS ARISING OUT OF EMPLOYMENT? YES ☐ NO ☐	5. IF ANSWER TO 4. IS YES, HAVE YOU OR THE PATIENT FILED, OR DO YOU INTEND TO FILE, A CLAIM FOR BENEFITS UNDER ANY FEDERAL OR STATE WORKERS' COMPENSATION LAW? YES ☐ NO ☐
6. IS PATIENT'S CONDITION DUE TO AN ACCIDENT, INJURY, OR ILLNESS CAUSED BY SOME OTHER PARTY? YES ☐ NO ☐	7. IF ANSWER TO 6. IS YES, HAVE YOU OR THE PATIENT FILED, OR DO YOU INTEND TO FILE, ANY LEGAL ACTION OR CLAIM AGAINST THE OTHER PARTY? YES ☐ NO ☐
8. IS PATIENT'S CONDITION DUE TO AN ACCIDENT? YES ☐ NO ☐	9. IF ANSWER TO 8, IS YES, HOW, WHERE, AND DATE.

10. 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, if any, due for this claim.

DATE ____________, 20____ SIGNATURE ______________________
EMPLOYEE PATIENT (or if a minor, PARENT)

MAILING ADDRESS ______________________

Optional

11. ASSIGNMENT OF BENEFITS I hereby assign benefits due me to the extent of expenses incurred and payable for injury or illness commencing ______________________ , 20____ to the following:

Hospital ______________________

Doctor ______________________

Other ______________________

DATE ____________ SIGNED ______________________
INSURED EMPLOYEE / SURVIVOR

12. **HOW TO FILE YOUR CLAIM** 1) Attach Medicare notice(s)

2) Mail to: **ILWU-PMA COASTWISE CLAIMS OFFICE**
814 MISSION STREET, SUITE 300
SAN FRANCISCO, CA 94103

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