

STATEMENT OF CLAIM FORM

RETURN COMPLETED CLAIM FORM TO: Kentucky Laborers District Council Health & Welfare Fund
★ Telephone: (502) 839-8166 ★ 1996 By Pass South ★ Lawrenceburg, Kentucky ★ 40342-9754 ★ Fax: (502) 839-3558

Member's Name _____ Soc Sec # |__|__|__|_|-|__|_|-|__|__|__|_| Local # _____

Member's Address _____ Birthdate _____
Street or P.O. Box City State Zip

Member's Telephone Number (____) _____ - _____

1. CLAIM IS MADE FOR (Check One): Self Dependent Spouse Dependent Child

2. IF CLAIM IS ON DEPENDENT SPOUSE OR CHILD PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Dependent's Full Name _____ Soc Sec # |__|__|__|_|-|__|_|-|__|__|__|_|

Relationship to Member _____ Birthdate _____ Single Married

Is Dependent Employed? Yes No If "Yes" give name and address Employer: _____

3. ARE YOU OR YOUR DEPENDENTS COVERED BY ANOTHER MEDICAL INSURANCE PLAN? Yes No

a. Give Name of other plan and Policy #: _____ Effective Date: _____

b. Give the Name and Birthdate of the Policy Holder Name: _____ Birthdate: _____

c. Please indicate who is covered under the other insurance: Self Spouse Children

4. ARE YOU OR YOUR DEPENDENTS COVERED BY MEDICARE? Yes No Medicare Effective Date: _____

If "Yes", who is covered? Self Spouse Children (Give Names) _____

5. IS THIS ILLNESS OR INJURY FROM OR RELATED TO THE CLAIMANT'S OCCUPATION? Yes No

If "Yes", explain: _____ Have you filed a Work Comp Claim? Yes No

6. IF CLAIM IS DUE TO AN ILLNESS THAT IS NOT RELATED TO AN ACCIDENTAL INJURY, DESCRIBE CONDITION:

7. COMPLETE ALL QUESTIONS BELOW IF CLAIM IS FOR INJURY/ACCIDENT:

Date of Accident: _____ Location of Accident: _____

Detailed Description of Accident: _____

NOTE: If injury or accident did not occur at home/own property, please complete the enclosed Accident Report & Subrogation Form.

*** NO claims will be processed until this information is received ***

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish Kentucky Laborers Health and Welfare Fund with full information regarding treatment rendered (including copies of records). I/We also authorize any Union, Trust Fund, Association, Employer, or Provider of Services to furnish the Kentucky Laborers Health and Welfare Fund with information regarding benefits to which I/We may be entitled. A photocopy hereof shall be as valid as the original.

NOTE: IF CLAIM IS FOR DEPENDENT, SPOUSE MUST ALSO SIGN BELOW:

Date Spouse's Signature

Date Member's Signature

ASSIGNMENT OF BENEFITS TO PROVIDER OF MEDICAL SERVICES

I hereby authorize payment to the physician, hospital or other service provider of any benefits otherwise payable to me but not to exceed the reasonable and customary charges for those services, unless such charges indicate payment has been made in full by me and there is no balance due.

Date Signature of Member