STATEMENT OF CLAIM FORM

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

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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 □ (GiveNames)_____

5. **IS THIS ILLNESS OR INJURY FROM OR RELATED TO THE CLAIMANT=S OCCUPATION?** Yes □ No □
   If AYes@, 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 <u>ALL</u> 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 *****

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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

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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