

**ARCHITECTURAL IRON WORKERS' LOCAL NO. 63
WELFARE FUND**

903 Commerce Drive, Suite 304 - Oakbrook, IL 60523
(630) 472-0626

EMPLOYEE'S STATEMENT

PROCESSING OF CLAIMS REQUIRES THAT YOU FULLY COMPLETE THIS FORM.

Have your physician or provider complete the reverse side of this form or attach itemized bills AND (if applicable) corresponding "Explanation for Payment" statements from Medicare or primary insurance. **DO NOT SUBMIT BALANCE DUE STATEMENTS.**

EMPLOYEE INFORMATION

	Home Local Union No. _____
Name of Employee _____	Date of Birth _____
Home Address _____	
City _____ State _____ Zip Code _____	Telephone no. () _____
Social Security No. _____ Occupation _____	Active <input type="checkbox"/> Retire Date _____
Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ Date of Social Security Award _____	
*NOTE: If recently married or divorced, indicate date(s) _____	

OTHER INSURANCE INFORMATION

NOTE: Attach copy of payment worksheet from other insurance or Medicare

Do you or your dependents have ANY other health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES please supply:	
1) Name of the person insured _____	Relationship to Employee: _____
2) Insured person's Social Security No. _____	Date of Birth _____ Policy No. _____
3) Insurance company name _____	Telephone No. () _____
4) Address, City, State, Zip _____	

DEPENDENT INFORMATION- If claim is for a Dependent

Name of Dependent _____	Relationship to Employee _____	Date of Birth _____
Is Dependent attending school? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is Dependent employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, where? _____
Name _____		
Address, City, State, Zip _____		
*NOTE: Attach letter from registrar of college/university indicating hours enrolled per semester.		

SICKNESS/INJURY INFORMATION *Required for all claims*

Nature of sickness or injury _____	
Date accident occurred or sickness first began _____	Date first treated _____
If injured, detailed description of HOW and WHERE accident occurred _____	
If patient required treatment in a hospital, indicate date treated next to type of treatment:	
10 Emergency Room _____	2) Outpatient Surgery _____
3) Admission- Discharge _____	
Name of Hospital _____	City _____ State _____
Name of physician(s) consulted 1) _____ 2) _____	
Did injury or sickness occur in the course of ANY employment? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you or do you intend to file this claim under Workers' Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO	

EMPLOYEE MUST COMPLETE IF APPLYING FOR DISABILITY BENEFITS

EMPLOYEE'S DISABILITY STATEMENT	Date Last Worked _____	Date Work Resumed _____	Might claim be covered by Workers' Compensation Law? <input type="checkbox"/> YES <input type="checkbox"/> NO
	*(Reverse side of this form MUST be completed by Employee's Physician)		

EMPLOYEE'S SIGNATURE

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 Trustees or their representative of any facts and or related records concerning the injury, illness, or treatment (including mental/ nervous and substance abuse) of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed _____ Dated _____

