LOCAL 705, I. B. of T.
HEALTH & WELFARE FUND

Return Completed Form To: 1645 WEST JACKSON BLVD. SUITE 700 • *Telephone* (312) 738-2811
CHICAGO, ILLINOIS 60612

TO BE COMPLETED BY INSURED PARTICIPANT

1. Participant's full name _____ I.D. Number _____ Date of birth _____ ☐ Male Sex: ☐ Female

   Home address _____ _____ Telephone number _____
   Number and Street City State Zip Code

2. Employed by _____ Occupation _____ Date of hire _____

3. If married, is Wife/Husband employed? ☐ Yes ☐ No Name of Wife/Husband _____

   Name of spouse's employer _____ Address of spouse's employer _____

   Does spouse have group insurance at place of employment? ☐ Yes ☐ No If "yes," give name and address of the insurance company _____

4. Are any hospital, surgical or medical benefits or services provided under any group plan other than shown above, or under any federal , state or other governmental program, auto insurance or third party liability insurance?
   ☐ Yes ☐ No If "yes," give name and address of insurance company or organization providing such benefits or services:

   _____

5. Patient (Check one) ☐ Self ☐ Dependent-Name _____ Relationship to Insured _____ Date of birth _____ ☐ Male Sex: ☐ Female

   Dependent's marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally separated

   Patient's address if different than Participant _____

6. Date accident occurred or sickness began _____, 20_____ ☐ A.M. ☐ P.M.

7. Describe injury or sickness _____

8. Date of first treatment for this injury or sickness _____, 20_____

9. IF PATIENT WAS INJURED, ANSWER THE FOLLOWING:

   a. Where did the injury occur? _____ Date and hour _____

   b. What was claimant doing when the injury occurred? _____

   c. Describe injury: Tell how it happened _____

   _____

10. Was the injury or sickness caused by any employment? ☐ Yes ☐ No

11. Has there been, or will there be, a claim filed for this disability with the worker's compensation carrier? ☐ Yes ☐ No

12. First full day unable to work _____, 20_____ Date returned to work _____, 20_____ Date expected to return to work _____, 20_____

13. I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

14. Date _____, 20_____ Participant's signature _____ Participant Sign Here

Patient's or Authorized Person's Signature:
I authorize the release of any medical or other information necessary to process the claim.

Signed (Patient, or Parent if minor) _____ Date _____

Insured's or Authorized Person's Signature:
I authorize payment of benefits directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services related to this claim.

Signed (Insured Person) _____ Date _____