Form W-1
2-93

Group Comprehensive Medical Benefits Claim

CONSTRUCTION INDUSTRY LABORERS
WELFARE - PENSION VACATION FUNDS

116 Commerce Drive
Jefferson City,
Missouri 65109-1196
(573) 893-2446

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Part 1 — EMPLOYEE COMPLETES IN ALL CASES

Name (Print) _____
(First) (MI) (Last)

Address _____
(Number and Street)

_____
(City) (State) (Zip)

Social Security No. _____ Birthdate _____

Marital Status: (Please Circle)

Single Married Divorced _____ Claim is for: Illness Injury Pregnancy Nature of Illness _____
(Date of Div.)

If an accident answer the following: Date _____ at (hour) _____ a.m. p.m. Did accident happen at work? Yes ☐ No ☐

How and where did the accident happen? _____

Date first treated _____ Date first disabled _____ **Local Union No.** _____

PART 2 — COMPLETE THIS SECTION IF CLAIM IS FOR YOUR DEPENDENT

Dependent's description: Must meet "Covered Dependent" status as defined in Summary Plan Description

Full Name _____ Date of Birth _____

Relationship _____ Single ☐ Married ☐ Divorced ☐ Full Time Student? Yes ☐ No ☐

PART 3 — EMPLOYEE MUST COMPLETE IN ALL CASES OR FORM WILL BE RETURNED

Do you have any other group insurance (including Medicare) Yes __ No__ Policy or Cert. No. _____

If "Yes" Insurance Company Name and Address _____

What is your spouse's name? _____ Is he/she employed? Yes ☐ No ☐

Name and Address of Spouse's Employer _____

Spouse's Social Security No. _____

Does spouse have other group insurance (including Medicare) Yes __ No__ Policy or Cert. No. _____

If "Yes" Insurance Company Name and Address _____

Are you or any of your dependents covered under any group medical plans other than shown above? Yes ☐ No ☐

If "yes", give name, address and policy # of the insurance company or organization providing such benefits or services. _____

I certify the above statements are true, complete, and accurate to the best of my ability; and authorize any physician, hospital, employer, insurance company, or other informant to furnish any information necessary to consider this claim. A photo copy of this authorization shall be as valid as the original. If the claim is for a dependent, the dependent meets the eligibility requirements as outlined in the Summary Plan Description.

Signature _____ EMPLOYEE SIGN HERE

Date this Claim Form Signed _____

FOR ADMINISTRATIVE USE ONLY

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below, but not to exceed the reasonable and customary charge for those services.

SIGNED

DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

SIGNED PATIENT OR PARENT IF MINOR

DATE

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S	EMPLOYMENT? YES ☐ NO ☐	PREGNANCY? YES ☐ NO ☐	IF YES, APPROXIMATE DATE PREGNANCY COMMENCED DATE

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED FROM THRU	PATIENT WAS PARTIALLY DISABLED FROM THRU

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	PATIENT WAS HOUSE CONFINED FROM THRU

DOES PATIENT HAVE OTHER HEALTH COVERAGE?

YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC.

1
2
3
4

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE CPT-4	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DX CODE	E CHARGES	

O—Doctor's Office IH—Inpatient Hospital NH—Nursing Home

H—Patient's Home OH—Outpatient Hospital OL—Other Locations

TOTAL CHARGES

AMOUNT PAID

BALANCE DUE

TAXPAYER I.D. NUMBER

THIS IS REQUIRED UNDER SECTION 6109 INTERNAL REVENUE SERVICE CODE AND APPLICABLE REGULATIONS THERETO

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE TELEPHONE