CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

Member's Application For Benefits

IMPORTANT — This form to be filled out by the member, doctor and employer immediately after the commencement of disability and forwarded to the office of Central PA Teamsters H&W Fund, P.O. Box 15224, Reading, PA 19612-5224 **IMPORTANT! All claims must be submitted within 45 days; bills within 90 days, to insure payment of claim.**

Name of Member				Identification No.	
Address Street		City	State	Zip Code	Phone ( )
Sex	Age	Member of Local Union No.	Employer		Job Classification
Do you have any other Group Health Ins.? No ☐ Yes ☐ If yes, give name of carrier					Carrier Phone No. ( )
Does your spouse have any other Group Health Ins.? No ☐ Yes ☐ If yes, give name of carrier					Carrier Phone No. ( )
Do you or your family have any other Non-Group Health Insurance? No ☐ Yes ☐					

DEPENDENT INFORMATION

Name of Dependent	Relationship	Sex	Birthdate
Does Dependent Work? *If So, Name & Address of Employer*		Employer Tel. No. ( )	

STATEMENT OF SICKNESS OR ACCIDENT (Must Be Completed By Member)

1. Date Sickness began or Accident occurred		
2. If Accident, how did it happen?		
3. Where did Accident happen?		On the Job?
4. Name of Sickness or Nature of Injury		
5. Date of first medical treatment for this disability		Where?
6. Name of Doctor		

ATTENDING PHYSICIAN'S STATEMENT — Member not allowed to complete this section.

1. Name of Patient	
2. Date Sickness began or Accident occurred	
3. Nature of Sickness or Injury	
4. Dates of all Medical Treatments	Office Home Hospital
5. If patient was hospitalized,	Where? From: To:
6. If an operation was performed,	What?
7. When in your opinion will the patient be able to work?	

ITEMIZED BILLS FOR HOSPITAL, SURGICAL AND MEDICAL EXPENSE MUST BE SUBMITTED

Physician's Signature: Non Corp. S.S.#

Address: Corp. Federal I.D. #

(NOTE: ALL BENEFITS ARE PAID TO EMPLOYEE UNLESS OTHERWISE ASSIGNED) DATE:

RELEASE: The statements are true and correct to the best of my belief. I hereby authorize any provider of services to furnish any information requested. I also hereby authorize my Health and Welfare Fund Administrator to release or obtain from any organization or person information which may be necessary to determine benefits payable under my Health and Welfare Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signed _____ **Date** _____
(Must Be Signed By Member Only)

ASSIGNMENT OF HEALTH AND WELFARE BENEFITS: I hereby authorize payment directly to the hospital and/or doctor all medical, surgical and hospital benefits entitled me on account of said disability. I understand I am financially responsible to the hospital and/or doctor for charges not covered by this assignment.

Signed _____ **Date** _____
(Must Be Signed By Member Only)

EMPLOYER'S STATEMENT — Member not allowed to complete this section.

1. Date of first full working day lost because of Sickness or Accident.	Date resumed work
2. Was claimant regularly employed and working for you when disability began?	Date employed
3. Is this being reported under Workmen's Compensation?	

Date:	**Employer's Signature:** **Official Position:**	**Employer Telephone No. ( )**

HW/MAFB