



United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund

9801 West Higgins Road, Suite 500 ♦ Rosemont, IL 60018-4740 ♦ 847-384-7000 ♦ 800-621-5133
Customer Service FAX 847-384-0196 ♦ ufcwmidwest.org

Statement of Claim — For Hospital, Surgical, Medical and/or Income Protection Benefits
Attach bill(s), complete the first page—complete second page if salary loss is involved—and return to above address.

Employee-Member and Claim Information—Receipt of this claim form does not guarantee payment of benefits
1. YOUR FULL NAME (EMPLOYEE-MEMBER) MAIDEN NAME UFCW ID# or SOCIAL SECURITY NUMBER
2. STREET ADDRESS CITY STATE ZIP CHECK IF NEW ADDRESS
3. DAYTIME AREA CODE/PHONE NUMBER GENDER DATE OF BIRTH MARRIAGE STATUS DATE MARRIED
4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED
5. FULL NAME OF PATIENT RELATIONSHIP TO EMPLOYEE-MEMBER
6. DESCRIPTION OF SICKNESS OR INJURY, INCLUDING FULL DESCRIPTION OF WHERE AND HOW INJURY HAPPENED—FAILURE TO SUPPLY ALL REQUESTED INFORMATION WILL DELAY PROCESSING OF YOUR CLAIM:
7. NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED THIS CONDITION DATE FIRST TREATED
8. DATE AND TIME OF INJURY OR BEGINNING OF SICKNESS IF YOU STOPPED WORK, GIVE DATE IF RETURNED TO WORK, GIVE DATE CHECK IF SICKNESS OR INJURY IS DUE TO THE PATIENT'S EMPLOYMENT (ON-THE-JOB) CHECK IF A WORKER'S COMPENSATION CLAIM HAS OR WILL BE FILED
Spouse Information—Complete for all Claims
9. FULL NAME OF SPOUSE DATE OF BIRTH SOCIAL SECURITY NUMBER
10. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS CITY STATE ZIP DAYTIME AREA CODE/PHONE NUMBER
11. NAME AND ADDRESS OF SPOUSE'S EMPLOYER (OR FORMER EMPLOYER) AREA CODE/PHONE NUMBER
Dependent Child Information—Complete Only if Claim is for a Dependent Child
12. DEPENDENT'S FULL NAME—FIRST AND LAST NAME RELATIONSHIP DATE OF BIRTH SOCIAL SECURITY NUMBER
13. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS CITY STATE ZIP DAYTIME AREA CODE/PHONE NUMBER
14. EMPLOYER NAME AND ADDRESS CHECK IF NOT EMPLOYED
Other Insurance Information—Complete for all Claims
15. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN, SUCH AS, GROUP BLUE CROSS, A SCHOOL PLAN, A GOVERNMENT PLAN, AN AUTO INSURANCE PLAN, ETC.? IF "YES," PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. YES NO
16. POLICYHOLDER'S FULL NAME—FIRST AND LAST NAME RELATIONSHIP TO EMPLOYEE-MEMBER DAYTIME AREA CODE/PHONE NUMBER
17. NAME OF PLAN OR COMPANY POLICY NUMBER
18. ADDRESS CITY STATE ZIP AREA CODE/PHONE NUMBER
Signatures—Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid
I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund or its legal representative, any and all such information. A photocopy of this authorization shall be as valid as the original.
Date Signature Employee-Member sign here
Date Signature Patient (or Parent) sign here
Assignment of Benefits: Authorization to Pay Benefits to Physician, Hospital or Other Provider—Sign only if benefits to be paid directly to provider
I hereby authorize payment directly to the physician or other provider for any Surgical and/or Medical Benefits otherwise payable to me for services in connection with this claim.
Date Employee-Member Signature

Statement of Claim — For Income Protection Benefits

A claim for Income Protection Benefits must be submitted immediately to the Benefits Fund Office. Subsequent **reports are required at least every three weeks** thereafter during the continuance of the disability. Failure to comply with these requirements will jeopardize your right to receive benefits. The Fund, at its own expense, has the right to have you examined by a doctor of its choice as often as it is necessary to establish total disability. If you do not submit to an examination requested by the Benefits Fund Office, benefits may not be paid.

To Be Completed by Disabled Employee-Member—Be sure you have signed on the front under "Signatures..."					
1. YOUR FULL NAME (EMPLOYEE-MEMBER)		UFCW ID# or SOCIAL SECURITY NUMBER	OCCUPATION		
Attending Physician's Statement for Disability Claim					
2. DIAGNOSIS AND CONCURRENT CONDITIONS (if Diagnosis Code other than ICDA used, please give name)					
3. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS CONDITION DUE TO PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES," APPROXIMATE DATE PREGNANCY COMMENCED	ESTIMATED DATE OF CONFINEMENT	
4. DATES OF SERVICE (If previous form submitted to this office, you need show only dates since last report)					
5. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work) FROM _____ THRU _____		IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	
6. DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES," PLEASE IDENTIFY _____			
7. PHYSICIAN'S NAME (PRINT)			DEGREE	AREA CODE/PHONE NUMBER	
8. STREET ADDRESS		CITY	STATE	ZIP	
Date _____ Physician's Signature _____					
Employer's Statement—Employer must complete if Salary Loss is involved					
9. FIRST FULL DAY UNABLE TO WORK		DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK	DATE AND TIME LAST WORKED	
10. BASIC GROSS WEEKLY EARNINGS		DATE TERMINATED	REASON FOR TERMINATION		
11. IF NOT PREVIOUSLY PROVIDED FOR THIS DISABILITY, INDICATE LAST 4 WEEKLY SALARIES PRIOR TO DATE STOPPED WORKING		WEEK #1	WEEK #2	WEEK #3	WEEK #4
12. PRIOR TO THIS DISABILITY, WAS THE EMPLOYEE <input type="checkbox"/> LAID OFF <input type="checkbox"/> ON LEAVE <input type="checkbox"/> RETIRED <input type="checkbox"/> DISCHARGED <input type="checkbox"/> QUIT					
13. IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			WILL A CLAIM BE MADE UNDER WORKER'S COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
14. NUMBER OF FULL & PARTIAL SICK DAYS PAID		SICK DAYS PAID FROM _____ THRU _____		NUMBER OF SICK HOURS PAID	
15. AREA CODE/PHONE NUMBER		VALIDATE WITH STORE STAMP			
Date _____ Authorized Signature—Employer _____					