EIGHTH DISTRICT ELECTRICAL BENEFIT FUND

P.O. BOX 30101 - SALT LAKE CITY, UTAH 84130-0101
TELEPHONE (801) 973-1001

STATEMENT OF CLAIM

PART A - EMPLOYEE'S STATEMENT

EMPLOYEE'S NAME | ☐ MALE ☐ FEMALE | DATE OF BIRTH | SOCIAL SECURITY NO

COMPLETE HOME ADDRESS | TELEPHONE NO

EMPLOYED BY | LOCAL UNION NO | ☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED

PATIENT IS ☐ SELF ☐ SPOUSE ☐ CHILD | NAME OF PATIENT | ☐ MALE ☐ FEMALE | DATE OF BIRTH

NAME OF SPOUSE | IS SPOUSE EMPLOYED? ☐ YES ☐ NO | NAME AND ADDRESS OF SPOUSE'S EMPLOYER

DATE ACCIDENT OR SICKNESS BEGAN | DID ACCIDENT OCCUR WHILE AT WORK? ☐ YES ☐ NO | HAS THERE BEEN OR WILL THERE BE A CLAIM FILED FOR THIS DISABILITY WITH THE WORKMEN'S COMPENSATION CARRIER? ☐ YES ☐ NO

NATURE OF SICKNESS OR INJURY
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?

ARE YOU OR YOUR DEPENDENT INSURED UNDER ANY OTHER GROUP INSURANCE OR GOVERNMENT PLAN WHICH WILL ALSO PAY FOR ANY OF THE MEDICAL EXPENSES OF THIS CLAIM?
☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS AND POLICY NUMBER OF INSURANCE COMPANY PROVIDING BENEFITS

NAME AND ADDRESS

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals or other institutions providing care, treatment, consultation, drugs, or supplies to furnish the Eighth District Electrical Benefit Fund with full information regarding medical history, physical or mental condition, consultation, treatment or psychotherapy rendered - including copy of their records. I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Eighth District Electrical Benefit Fund with the information regarding benefits to which I/We may be entitled. (If claim for spouse, spouse also must sign.) A photostatic copy of this authorization shall be considered as effective and valid as the original.

DATE | SPOUSE'S SIGNATURE | EMPLOYEE'S SIGNATURE

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

Employee's Signature | Date

PART B - ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME | DATE OF BIRTH

DIAGNOSIS AND CONCURRENT CONDITIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF
PATIENTS EMPLOYMENT ☐ YES ☐ NO AUTOMOBILE ACCIDENT ☐ YES ☐ NO PREGNANCY ☐ YES ☐ NO

REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICE SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES*	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE RVS CODE	CHARGES

CLAIMS OFFICE USE ONLY

* O = DOCTORS OFFICE IH = IN-PATIENT HOSPITAL NH = NURSING HOME
H = PATIENT'S HOME OH = OUT-PATIENT HOSPITAL OL = OTHER LOCATIONS

TOTAL CHARGES $
AMOUNT PAID $
BALANCE DUE $

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 (UNABLE TO WORK)
FROM THRU | DATE LAST DAY WORKED

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK | DATE EMPLOYEE RETURNED TO WORK

DOES PATIENT HAVE OTHER HEALTH COVERAGE ☐ YES ☐ NO IF "YES" PLEASE IDENTIFY

DATE | PHYSICIAN'S NAME (PRINT) | SIGNATURE | DEGREE | TELEPHONE

STREET ADDRESS | CITY, STATE, ZIP CODE

INDIVIDUAL PRACTITIONERS SS# | ALL OTHER EMPLOYER I.D. SS#

The undersigned hereby certifies that except as above stated the person on whose behalf benefits are applied for is not entitled to similar benefits from any other Plan as that term is defined in Article XIV (1) (a) of the Rules and Regulations for the Eighth District Electrical Benefit Fund. If benefits similar to the benefits paid under this Plan on behalf of such person are determined to have been available under any other Plan, the undersigned agrees to reimburse this Plan for all benefits paid under this Plan in the order established in Article XIV paid under this plan in the order established in Article XIV of the Rules and Regulations which would have been payable under such other Plan had claims therefore been duly made. The right of reimbursement includes the right of the Plan to deduct the amount thereof from all future benefits to be paid or payable to the undersigned or his beneficiary under the Plan. The undersigned does hereby assign to this Plan any and all rights the undersigned or such person may have to such benefits available under any other Plan.

Signature _____