

# Electrical Workers General Welfare Fund

28600 Bella Vista Parkway, Suite 1110

Warrenville, IL 60555-1600

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NOTICE TO PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

## ANNUAL CLAIM FORM

At least one Claim Form must be completed each year, for each family

Member's Name\* \_\_\_\_\_

S.S No \_\_\_\_\_

Street Address- \_\_\_\_\_

Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is Member covered -under any other insurance plan? YES  NO

If YES, Name of other carrier: \_\_\_\_\_

Type of Coverage (check all that apply) Medical  Dental  Vision  Single  Family

spouse's Name \_\_\_\_\_ Date of Birth- \_\_\_\_\_ Lives with Member? YES  NO

Is spouse employed? YES  NO

If yes, Name and Address of Employer \_\_\_\_\_

Is spouse covered under another insurance plan? YES  NO

If yes, Name of other carrier \_\_\_\_\_

Address: \_\_\_\_\_

Name of Company providing coverage \_\_\_\_\_

Policy No \_\_\_\_\_ Effective Date \_\_\_\_\_

Type of Coverage (check all that apply) Medical  Dental  Vision  Single  Family

List all-eligible dependents

Name	Employed?	Lives with Employee?	Other Insurance?
_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	If Other Insurance, Name of Carrier _____	_____	_____
_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	If Other Insurance, Name of Carrier _____	_____	_____
_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	If Other Insurance, Name of Carrier _____	_____	_____
_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	If Other Insurance Name of Carrier _____	_____	_____
_____	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	If Other Insurance Name of Carrier _____	_____	_____

FAILURE TO FULLY COMPLETE ALL OF THE ABOVE INFORMATION COULD RESULT IN AVOIDABLE DELAYS IN YOUR REIMBURSEMENT

### MEMBER'S SIGNATURE REQUIRED - PLEASE READ

I/We hereby certify the above statements are true and complete to the best of my knowledge I/We authorize release when requested by of this Fund its representatives, all Doctors, Hospitals, or other institutions, any facts concerning the injury, illness, treatment, or benefits paid to or on behalf of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Date

(Member's Signature)