

Group Comprehensive Medical Benefits Claim

**CONSTRUCTION
INDUSTRY LABORERS
WELFARE - PENSION
VACATION FUNDS**

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

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 _____

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