

EMPLOYEE: IT IS YOUR RESPONSIBILITY TO COMPLETE AND SIGN THE EMPLOYEE'S STATEMENT BELOW:

CLAIM FOR BENEFITS

HOW TO FILE YOUR CLAIM

1. You must FULLY COMPLETE the EMPLOYEE'S STATEMENT and SIGN IT.
2. Attach the bills for the medical expense benefits you are claiming. These bills must be itemized and show the patients name, condition being treated (diagnosis), type of treatment given, date the expense incurred and the charges made.
3. A Physician's Statement is provided on the back of this form for your convenience.
4. RETURN FULLY COMPLETED FORM with attached medical claims to address below.

EMPLOYEE'S STATEMENT						
Fully Complete For All Claims	Employee's Name (Please Print)		Group Number 41593	Birthday (MO. DA. YR.)		Social Security Number
	Address: Street and No.		City	State	Zip Code	
	I am: <input type="checkbox"/> Active <input type="checkbox"/> Retired		This claim is on:		<input type="checkbox"/> Myself <input type="checkbox"/> Wife/Husband <input type="checkbox"/> Dependent Child	
	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give name of spouse and name and address of spouse's employer.	
	Name of Spouse _____ Name of Spouse _____		Spouse's Birthday _____		Social Sec. No. _____	
Complete For All Claims	Name of Spouse's Employer _____			Address _____		
	What was the sickness or injury?			On what date did it begin?		Date of first expense for this condition
	Are any of the expenses being claimed covered by:					
	(a) Other group health care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		(c) A group Blue Cross Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Give name of Employer _____ Other insurance company and policy number _____		Give group number _____ Give certificate number _____			
(b) Government insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		(d) School insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What type? _____						
Is COBRA applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of COBRA _____						
If these expenses are covered by other insurance and the other carrier is primary (that is, pays first), don't file this claim until you have received the payment from the other insurance. Submit the explanation of benefits from the other carrier with this claim.						
Complete For All Injuries Employee or Dependent	Date the injury?	Where did the injury occur?		How did the injury occur?		
	Is injury due to automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has or will claim be filed under any Worker's Compensation Act or similar law? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Complete Only For Dependent Claims	Name of dependent		Birthday (MO. DA. YR.)	Relationship of dependent		<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed
	Date you covered this Dependent	If child 19 or over is (s)he dependent upon your maintenance and support? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is (s)he a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If student give name and location of school.						
Complete Only For Disability Claims	From and to what dates were you continuously totally disabled from performing any work?					
	From _____ 20 ____ to _____ 20 ____					
Date you were first able to do any work? _____						
Sign Here	I hereby authorize the release to and use by the ILA Employers Welfare Fund of any medical or other information needed in processing this claim and certify that the above information is correct.					
	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. I hereby certify to the above statements.					
Date _____ 20 ____ Employee sign here X _____						
ADMINISTRATIVE STATEMENT						
The above Employee's Name, Address, Group Number and Social Security Number are correct <input type="checkbox"/>			Was coverage in effect when expense incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please file claim with:						
ILA EMPLOYERS WELFARE FUND 510 W. BRYAN STREET P.O. BOX 1280 SAVANNAH, GEORGIA 31498-1280			SIGNED _____ DATE _____			
Remarks:						

