IRON WORKERS TRUST FUND LOCAL NO.5

EMPLOYEE STATEMENT

☐ **Check here if your address is new.**

PART 1 – EMPLOYEE INFORMATION

EMPLOYEE NAME – First / Initial / Last	☐ M ☐ F	EMPLOYEE WPAS ID # OR SSN	EMPLOYEE BIRTH DATE Mo. Day Year

HOME ADDRESS STREET	CITY	STATE	ZIP	PHONE

EMPLOYED BY	LOCAL NO.

PATIENT'S NAME – First / Initial / Last	☐ M ☐ F	PATIENT ID # OR SOCIAL SECURITY NO.	PATIENT BIRTH DATE Mo. Day Year	RELATION TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child

EMPLOYEE MARITAL STATUS	IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU	IF DEPENDENT CHILD IS AGE 19 OR OLDER, DOES HE/SHE HAVE ACCESS TO INSURANCE THROUGH HIS/HER EMPLOYMENT? ☐ YES ☐ NO IF YES, WAS COVERAGE DECLINED? ☐ YES ☐ NO IF DEPENDENT CHILD IS AGE 26 OR OLDER, DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? ☐ YES ☐ NO
☐ MARRIED ☐ LEGAL SEP. ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ STEPCHILD ☐ GUARDIANSHIP ☐ OTHER (EXPLAIN) _____	

NAME OF SPOUSE (if not patient listed above)	SPOUSE BIRTH DATE Mo. Day Year	SPOUSE ID # OR SOCIAL SECURITY NO.

IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME & ADDRESS OF SPOUSE'S EMPLOYER	DOES SPOUSE'S EMPLOYER OFFER GROUP HEALTH INSURANCE? ☐ YES ☐ NO DID SPOUSE DECLINE THAT COVERAGE? ☐ YES ☐ NO

PART 2 – INSURANCE INFORMATION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? ☐ YES ☐ NO

IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME _____ ADDRESS_____

NAME OF SUBSCRIBER _____ SUBSCRIBER ID # OR SOCIAL SECURITY NO. _____

OTHER GROUP PLAN COVERS: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN OTHER GROUP PLAN POLICY OR I.D. NO. _____

OTHER GROUP PLAN INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? ☐ YES ☐ NO IF YES

- NAME OF PERSON COVERED _____
- MEDICARE EFFECTIVE DATE _____

PART 3 – ACCIDENT/INJURY INFORMATION

WAS CARE REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO DID ACCIDENT OCCUR WHILE AT WORK? ☐ YES ☐ NO

DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____

HAS CLAIM BEEN FILED WITH WORKERS' COMPENSATION? ☐ YES ☐ NO IF "YES", GIVE CLAIM NUMBER _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. **Do not sign if bills have been paid.**

Employee Signature _____ Date _____

I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original.

Patient Signature (if not minor child) _____

Employee Signature _____ Date _____

PROCEDURE FOR FILING A CLAIM

1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
2. Attach an itemized bill for all charges relating to this claim. **If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" on the reverse side of this form.**
3. Complete a separate form for each patient.
4. **Mail completed form and itemized medical bills to:**

IRON WORKERS TRUST FUND LOCAL NO. 5
P.O. BOX 34945
SEATTLE, WASHINGTON 98124-1945
PHONE: (206) 441-7574 OR (877) 367-0541

To ensure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) provider name and address; b) date of service; c) diagnosis; d) procedure done and e) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable.

If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching insurance or Medicare payment explanation.

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	AGE

DIAGNOSIS AND CONCURRENT CONDITIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ NO IF "YES", APPROXIMATE DATE PREGNANCY COMMENCED:

COMPLETE REPORT OF SERVICES OR ATTACH AN ITEMIZED BILL. IF A PREVIOUS FORM HAS BEEN SUBMITTED, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.

DATES OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	C.P.T. PROCEDURE CODES	CHARGES

TOTAL CHARGES	**$**
AMOUNT PAID	**$**
BALANCE DUE	**$**

THIS AREA MUST BE COMPLTED BY THE ATTENDING PHYSICIAN IF APPLYING FOR DISABILITY WAIVERS.

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF "YES", WHEN AND DESCRIBE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) GIVE DATES: FROM THRU	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 PHONE

INDIVIDUAL PRACTITIONERS TIN OR SS NO.	

SEE OTHER SIDE FOR INSTRUCTIONS FOR FILING A CLAIM

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION MAY BE OBTAINED FROM:
WELFARE & PENSION ADMINISTRATION SERVICE, INC.
PHONE: (206) 441-7574 or 1-877-367-0541
www.iw5benefits.org