RETURN COMPLETED FORM TO:
WASHINGTON-IDAHO CARPENTERS HEALTH AND SECURITY PLAN
P.O. BOX 5434 (509) 328-0300
SPOKANE, WASHINGTON 99205-0434

STATEMENT OF CLAIM FOR BENEFITS

TO BE COMPLETED BY EMPLOYEE

SIGN WHERE INDICATED
ANSWER ALL QUESTIONS THAT APPLY

Member's full name	Member's Marital Status	M		Div.		☐ Male	Date of birth	Soc. Sec. Number
		S		Legal				
		Wid.		Sep.		☐ Female		

Home address	(Number and Street)	(City)	(State)	(Zip Code)	Telephone Number
Employed by			Local Union No.		Date employed

Name of patient ______________________ **Date of Birth** ______________________
(Print) (Month) (Day) (Year)

If patient is a dependent, state relationship to insured employee ______________________

Is dependent employed?______ **If so, where?**______________________

Are you or any of your dependents entitled to benefits under any group plan, school insurance, or Medicare?
Yes ☐ **No** ☐
If yes, give name of Policy Holder ______________________

Give group policy number ______________________

Name and phone number of insurance company ______________________

IF PATIENT WAS INJURED (COMPLETE IN ALL CASES OF INJURY)				
Date accident occurred	Time:	☐ A.M. ☐ P.M	Was claimant at work when the accident occurred ☐ Yes ☐ No	
Describe accident (Tell how, when and where it occurred)				

Is this patient's condition related to employment? **Yes** ☐ **No** ☐

IF PATIENT IS THE EMPLOYEE, ALSO COMPLETE THE FOLLOWING TWO LINES
Date employee last worked prior to current disability ______________________, 20 ______

First date physically unable to work ____________ Date returned or available for work ____________

I/we jointly certify that the above information is true and correct. I/we hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish Washington-Idaho Carpenters Health and Security Plan with full information regarding treatment rendered (including copies of their records). I/we also authorize any Trust Fund, employer or insurance carrier to furnish Washington-Idaho Carpenters Health and Security Plan with information regarding benefits to which I/we may be entitled. (If claim for spouse, spouse also must sign.) A copy or photocopy of this authorization shall be considered as effective and valid as the original. **UNDER PENALTY OF LAW I HEREBY DECLARE THAT I HAVE READ THE ABOVE AND SWEAR THAT IT IS TRUE, CORRECT, AND COMPLETE.**

*Employee's Signature ______________________ Date Signed ______________________

*Spouse's Signature ______________________

PLEASE BE SURE ALL BILLS ARE FORWARDED WITH THIS CLAIM FORM
OPPOSITE SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN

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ATTENDING PHYSICIAN'S STATEMENT

Patient's name and address | Age

Employees name if patient is a dependent

Diagnosis and concurrent conditions (if diagnosis code other than ICDA* used, give name) Accident? Yes [ ] No [ ]

Is condition due to injury or sickness arising out of patient's employment?
Yes [ ] No [ ]

Pregnancy
Yes [ ] No [ ]

If yes, approximate date pregnancy commenced.
Date

Report on services (or attach itemized bill) (if previous form submitted to this Plan' you need only show dates and services since last report)

Date of Services	Place of Services§	Description of surgical or medical services rendered	PROCEDURE CODE—IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	Charges

§ — DOCTOR'S OFFICE IH — INPATIENT HOSPITAL NH — NURSING HOME
H — PATIENT'S HOME OH — OUTPATIENT HOSPITAL OL — OTHER LOCATIONS
*ICDA — INTERNATIONAL CLASSIFICATION OF DISEASES
**CPT — CURRENT PROCEDURAL TERMINOLOGY (CURRENT EDITION)

TOTAL CHARGES $__________

AMOUNT PAID $__________

BALANCE DUE $__________

Date symptoms appeared or accident happened.

Date patient first consulted you for this condition.

Patent ever had same or similar condition?
Yes [ ] No [ ]

Patient still under your care for this condition?
Yes [ ] No [ ]

Patient was continuously totally disabled (unable to work)
From Thru

If still disabled, date patient should be able to return to work.

Does patient have other health coverage? Yes [ ] No [ ]
If "Yes" please identify.

Signed ____________________
(Attending Physician) Degree

Date ____________, 20 ______

Address ____________________

Phone ____________________

Tax I.D. Number ____________________

PART 2
IF PAYMENT IS TO BE MADE TO DOCTOR OR HOSPITAL, PLEASE FILL IN:

Name of doctor or hospital and its location ____________________

I hereby authorize payment to the above named doctor or hospital of the Group Benefits payable to me, but not to exceed the regular charges for this period of treatment. I understand that I am financially responsible to the doctor or hospital for charges not covered by our Benefit Plan.

Employee's Signature ____________________