

RETURN THIS FORM TO:

UFCW - EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA

MAILING ADDRESS: P.O. Box 9000, WALNUT CREEK, CA 94598-0900

(925) 746-7530
800-794-5678

FUND OFFICE USE ONLY		
Julian Day	Adjuster	Number
CONTINUING		

**STATEMENT OF CLAIM FOR
GROUP HOSPITAL - SURGICAL - MEDICAL BENEFITS**

"In consideration of the payment of benefits by the Trust relating to the illness or injury on which this claim is based it is understood that the undersigned employee and/or his dependents will be required, in order to receive benefits from the Trust, to execute an assignment to the Trust, as required by its Rules, if the employee and/or his dependents recovers any amount by judgment, compromise or settlement from any third party who may be liable for such illness or injury."

PART I. TO BE COMPLETED BY THE EMPLOYEE CLAIMING BENEFIT FOR SELF OR DEPENDENT

1. Print name of Participant _____ Participant
LAST NAME FIRST NAME MIDDLE INITIAL
 Soc. Sec. No. _____
 Sex _____ Date of Birth _____ Married _____ Union Local No. _____
 Print any Previous Name under which you filed a claim _____ Home Phone _____

2. Name of Spouse _____ Spouse's Date of Birth _____ Spouse's Soc. Sec. No. _____

3. Home Address _____
NUMBER AND STREET CITY ZIP CODE

4. Claim is made for: Participant _____ (NAME OF PATIENT) _____ (RELATIONSHIP) _____ (DATE OF BIRTH) _____ (SEX) _____ (AGE) _____
 Dependent
 Does your dependent live with you? YES NO

5. Name of Company where your SPOUSE is employed _____
 Address of Company _____

6. Is patient's condition due to injury or illness which occurred on the job? YES NO If yes, complete question 7.

7. Have you filed a claim for Worker's Compensation for this disability? YES NO Date of injury _____
 If "yes," please explain _____

8. Is patient covered by Medicare? YES NO If yes, effective date _____

9. Is patient covered by other Medical Insurance? YES NO If yes, effective date _____

10. If yes, please complete the following information:

_____	POLICY NUMBER OR SOCIAL SECURITY NUMBER
NAME OF PERSON INSURED BY OTHER INSURANCE	NAME OF EMPLOYER
NAME OF INSURANCE COMPANY	ADDRESS OF EMPLOYER
ADDRESS OF INSURANCE COMPANY	LOCAL UNION NUMBER (IF ANY) - INSURANCE IDENTIFICATION NUMBER (IF ANY)

TO BE COMPLETED IF PATIENT IS INJURED

11. Where did the injury occur? _____ Date and Hour _____

12. Tell how it happened _____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

Date this Claim Form Signed _____ Participant's Signature _____ Participant Sign here

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(1) Patient's name _____ Age _____

(2) Nature of sickness or injury. (Describe complications if any) _____

(3) Did this sickness or injury arise out of patient's employment? Yes No

If "Yes," explain _____

(4) Nature of surgical or obstetrical procedure, if any (Describe fully) _____

(5) Date performed _____ 20 _____

Charge for this procedure? _____ 1974 CRVS Procedure No. _____

Where performed _____ If in hospital, in-patient _____ out-patient _____

(6) Give dates of treatments:	1974 R.V.S.	Description	Fee Charged

Date _____ 20 _____ Signed _____ Degree _____

PRINT OR TYPE DOCTOR'S NAME

Physician's
 Soc. Sec. # _____
 or
 Taxpayer # _____

Address _____ (STREET) _____ (CITY) _____ (STATE)

Phone _____

PART III.

TO BE COMPLETED AND SIGNED BY THE PARTICIPANT IF DIRECT PAYMENT OF BENEFITS TO THE SURGEON OR PHYSICIAN IS DESIRED. (THIS ASSIGNMENT WILL NOT BE HONORED IF SIGNED BY A DEPENDENT OR PERSON OTHER THAN THE PARTICIPANT.) PERSONAL DATED SIGNATURE OF PARTICIPANT IS REQUIRED IN ORDER TO ASSIGN BENEFITS.

PARTICIPANT'S ASSIGNMENT

I hereby assign Benefits to the Physician indicated hereon which are payable as a result of this claim as established herein or by statement attached.

(Read before signing)

DATED _____ SIGNED _____
Signature of Participant