RAILROAD MAINTENANCE AND INDUSTRIAL HEALTH AND WELFARE FUND
MEDICAL CLAIM STATEMENT

2725 W. Monroe Street
Springfield, IL. 62704

Member/Participant/Employee Information

Member/Participant Name: _____ **Social Security Number:** _____
Current Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____
Date of Birth: _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other (Describe)** _____
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**
Participant Other Insurance Information – This may include coverage by a parent or spouse, Medicare, etc.
Type of Coverage: ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Prescription Drug**
Policyholder Name: _____ **Insurance Company (Carrier) Name:** _____
Identification Number: _____ **Group Number:** _____
****Please enclose a copy of the front and back of the ID cards****

Spouse Information

Name: _____ **Date of Birth:** _____ **Social Security Number:** _____
Current Address (If different from Member/Participant): _____ **City:** _____ **State:** _____ **Zip Code:** _____
Cell Phone: _____ **Email Address:** _____
Employed: ☐ **Full Time** ☐ **Part Time** ☐ **Not Employed**
Name of Spouse's Employer: _____
Address of Spouse's Employer: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Spouse Other Insurance Information – This may include coverage by a parent, Medicare, Medicaid, etc.
Type of Coverage: ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Prescription Drug**
Policyholder Name: _____
Insurance Company (Carrier) Name: _____
Identification Number: _____ **Group Number:** _____
****Please enclose a copy of the front and back of the ID cards****

Dependent Information

Name: _____ **Relationship:** _____ **Sex:** _____ **Date of Birth:** _____
(i.e.., Natural Child, Stepchild)
Current Address (If different from Member/Participant): _____ **City:** _____ **State:** _____ **Zip Code:** _____
Employed: ☐ **Full Time** ☐ **Part Time** ☐ **Not Employed**
Name of Dependent's Employer: _____
Address of Dependent's Employer: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Other Insurance Information – This may include coverage by a parent, spouse, Medicare, Medicaid, etc.
Type of Coverage: ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Prescription Drug**
Policyholder Name: _____
Insurance Company (Carrier) Name: _____
Identification Number: _____ **Group Number:** _____
****Please include a copy of the front and back of the ID cards***

PLEASE ALSO COMPLETE REVERSE SIDE

If Claim is for illness, briefly describe: (for example: heart, pregnancy, or annual completion of form)

_____

If Claim is for accident or injury provide:

Date/Time of Accident: _____Where Did it Happen: ☐ Work ☐ Home ☐ Other (Describe)_____

How did it happen: _____

If an illness or sickness, was it caused by work? ☐ Yes ☐ No If an injury, did it occur at work? ☐ Yes ☐ No

RELEASE OF INFORMATION

I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to this Fund or their duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. Such information may be used to the extent deemed necessary to determine the validity or amount payable in regard to claims.

_____ _____

Member's/Participant's Signature **Date**

_____ _____

Patient's Signature (Parent if Patient is a Minor) **Date**

AUTHORIZATION TO PAY BENEFITS (Complete Only if you want payment to go directly to the provider)

I hereby authorize payment directly to the provider of services for the enclosed expenses as provided under the Railroad Maintenance and Industrial Health and Welfare Fund Benefit Plan. I understand that I am financially responsible for charges not covered by this authorization.

Member/Participant Signature _____Date_____

(This assignment may not be honored if signed by a Spouse or Dependent or person other than the covered Member/Participant)

THIS FORM MUST BE COMPLETED FOR EACH COVERED PERSON

EVERY CALENDAR YEAR BEFORE ANY CLAIMS CAN BE PROCESSED

IF THIS FORM IS NOT PROPERLY SIGNED AND OTHER INSURANCE INFORMATION IS NOT PROVIDED, THIS FORM WILL BE RETURNED TO YOU FOR PROPER COMPLETION AND PAYMENT OF THAT COVERED PERSON'S CLAIMS WILL BE DELAYED