I.B.E.W./NECA SOUND & COMMUNICATIONS HEALTH AND WELFARE TRUST

BLUE CROSS PRUDENT BUYER PLAN
P.O. BOX 60007
LOS ANGELES, CA 90060-0007

IMPORTANT

PLEASE TAKE TIME TO CHECK OVER THIS FOAM TO MAKE SURE YOU HAVE ANSWERED ALL QUESTIONS, YOUR COOPERATION WILL HELP YOUR TRUST FUND TO GIVE YOU PROMPT AND EFFICIENT SERVICE.

PART 1

1 ELIGIBLE EMPLOYEE _____ (FIRST / INITIAL / LAST) MALE ☐ FEMALE ☐ SSN _____ / _____ / _____

NAME OF CURRENT EMPLOYER: _____

2 _____ (STREET ADDRESS)

_____ (CITY / STATE / ZIP)

NAME OF _____ BIRTH DATE _____

3 IF PATIENT IS YOUR DEPENDENT, GIVE RELATIONSHIP _____

4 IF PATIENT IS A CHILD, DO YOU CLAIM AS INCOME TAX DEDUCTION? YES ☐ NO ☐

MARRIED ? YES ☐ NO ☐ WORKING ? YES ☐ NO ☐ IF YES, NUMBER OF HOURS PER MONTH _____

ARE YOU MARRIED? YES ☐ NO ☐ IF YES, SPOUSE NAME: _____

5 IS SPOUSE EMPLOYED? YES ☐ NO ☐ NAME OF EMPLOYER _____

DOES SPOUSE HAVE GROUP INSURANCE AT PLACE OF EMPLOYMENT YES ☐ NO ☐

IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY PROVIDING SUCH BENEFITS _____

_____

POLICY AND/OR GROUP NUMBER _____ SPOUSE SSN _____ / _____ / _____

TO BE COMPLETED BY SPOUSE: I HEREBY AUTHORIZE ANY UNION, TRUST FUND, EMPLOYER OR INSURANCE COMPANY TO FURNISH I.B.E.W./NECA SOUND & COMMUNICATIONS HEALTH AND WELFARE PLAN WITH INFORMATION REGARDING BENEFITS TO WHICH I/WE MAY BE ENTITLED.

6 DATE SIGNED _____ SIGNATURE _____

WAS PATIENTS CONDITION CAUSE BY HIS EMPLOYMENT? YES ☐ NO ☐

7 IS PERSON FOR WHOM CLAIM IS MADE ELIGIBLE FOR MEDICARE? YES ☐ NO ☐

8 COMPLETE THIS SECTION IF CLAIM IS DUE TO AN ACCIDENT:

9 _____

DATE OF INJURY TIME - A.M. P.M. WHERE DID INJURY OCCUR

FULL DETAILS OF ACCIDENT: _____

_____

_____

PART 2

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or relnsuring com pany, consumer reporting agency, or employer having Information available as to diagnosis, treatment a[ld prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical Information of me or my dependents to give to UNITED ADMINISTRATIVE SERVICES, the legal representative of the above named Trust, any and all such Information.

I UNDERSTAND the Information obtained by use of the Authorization will be used by UNITED ADMINISTRATIVE SERVICES, legal representative of the above named Trust, to determine eligibility for benefits under an existing policy. Any information obtained will not be released by UNITED ADMINISTRATIVE SERVICES to any person or organization EXCEPT to relnsurlng companies, or other persons or organizations performing business or legal services In connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.
I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this AUTHORIZATION shall be valid during the pendency of this claim.

THIRD PARTY LIABILITY

I AGREE to reimburse the Fund for any benefits paid by the Fund on this claim in the event of any recovery from any third party responsIble for the injury or sickness upon which it is based.

UNION LOCAL NO. _____ SIGNED _____
EMPLOYEE SIGNATURE

ADDRESS _____
NUMBER STREET

DATE SIGNED _____ CITY _____ STATE _____ ZIP _____

PART 3 PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT NAME (*FIRST, MI, LAST)*	2. PATIENT DATE OF BIRTH	3. INSURED'S NAME (*FIRST, MI, LAST)*
4. PATIENTADDRESS (STREET, CITY, STATE, ZIP	5. PATIENT SEX MALE ☐ FEMALE ☐	6. INSURED'S ID No. OR MEDICARE No.*(INCLUDE ANY LETTERS)*
	7. PATIENT RELATION TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. INSURED 'S GROUP No. (*OR GROUP NAME)*
9. OTHER HEALTH INSURANCE COVERAGE-ENTER NAME OF POLICY HOLDER, PLAN NAME, ADDRESS, POLICY OR MEDICAL ASSISTANCE NUMBER	10. WAS CONDITION RELATED TO: A. PATIENTS EMPLOYEMENT YES ☐ NO ☐ B. AN AUTO ACCIDENT YES ☐ NO ☐	11. INSURED'S ADDRESS *(STREET, CITY, STATE, ZIP)*

12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process the claim and request payment of benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. ASSIGNMENT OF BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described below due under this Health Plan. I understand that this assignment gives the Plan administrator the authority to make payment to the undersigned physician and that this assignment cannot be revoked after services have been rendered to me without the written consent of the physician.

(INSURED OR AUTHORIZED PERSON) -- ORIGINAL SIGNATURE REQUIRED

PART 4 PHYSICIAL OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION:	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐

17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(IF OTHER THAN HOME OR OFFICE)*		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3 ECT. OR DX CODE

1)
2)
3)
4)

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN	26. TOTAL CHARGE $ 0.00	27. AMT PAID	28. BAL DUE
	29. YOUR SOCIAL SECURITY No.		
SIGNED DATE			

30. PHYSICIAN OR SUPPLIERS NAME, ADDRESS, ZIP & TELEPHONE

ID No.

31. YOUR PATIENT ACCOUNT No.	32. YOUR EMPLOYER I.D. No.