ILWU-PMA COASTWISE CLAIMS OFFICE WELFARE PLAN

Medicare Supplemental Hospital, Medical, and Surgical Benefits Claim Form

(For Retirees, their Dependents or Survivors Enrolled Under Part A and Part B of Medicare)

1. **IDENTIFICATION** EMPLOYEE'S NAME: _____ ☐ Retired ☐ Survivor

   Date of Birth: _____ Local Number: _____ Registration Number: _____

   If claim is for Spouse, insert SPOUSE'S NAME: _____

2. **EXPLANATION:** Medicare will send you a record of the action taken on your Medicare claim – A **Record of Hospital Benefits used under Medicare**, or an **Explanation of Benefits, Medical Insurance**. The Medicare notice(s) must be submitted with this claim.

   TO COMPLETE THIS CLAIM, fill in Part 1, Sign the Authorization (Part 10). If you want payments made directly to the hospital or doctor even when claim is for your spouse, complete and sign the*Optional Assignment (Part 11)*.

3. Is the patient covered by any other Group Insurance or Health Services Plan? Yes ☐ No☐

   If Yes, what is the Policy Number: _____, Name of Other Plan: _____

   Address of Other Plan: _____
   (Street) *(City & State)* *(Zip Code)*

4. Is patient's condition due to an accident, injury, or illness arising out of employment? Yes ☐ No ☐	5. If answer to #4 is yes, have you or the patient filed, or do you intend to file, a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐
6. Is patient's condition due to an accident, injury, or illness cause by some other party? Yes ☐ No ☐	7. If answer to #6 is yes, have you or the patient filed, or do you intend to file, any legal action or claim against the other party? Yes ☐ No ☐
8. Is patient's condition due to an accident? Yes ☐ No ☐	9. If answer to #8 is yes, how, where, and date.

10. The above answers are true and complete to the best of my knowledge and belief, I authorize any physician, medical institution druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE (P.O. Box 429101, San Francisco, CA 94142) as is required to properly pay all benefits, if any due for this claim.

    Employee Signature: _____ Date: _____

    Patient (or if Minor, a Parent): _____ Date: _____

(Optional)

11. **ASSIGNMENT OF BENEFITS:** I hereby assign benefits due me to the extent of expenses incurred and payable for injury or illness commencing _____, 20_____ to the following:

    Hospital: _____

    Doctor: _____

    Other: _____

    Date: _____ Signed: _____
    (Insured Employee / Survivor)

HOW TO FILE YOUR CLAIM:

(1) Attach Medicare Notice(s);
(2) Mail to: ILWU-PMA COASTWISE CLAIMS OFFICE
P.O. Box 429101
San Francisco, CA 94142