ILWU-PMA WELFARE PLAN

Hospital, Medical, and Surgical Benefits Claim Form

Employee to fill out Part 1.Have your doctor fill out Part 2.
Note: For Hospital Benefits attach itemized bill.

PART 1 – EMPLOYEE STATEMENT

1. Name of Employee:	2. Local Number:	3. Registration Number:	4. Member ID Number:	5. Single ☐ Married☐

6. Address (Street, City, State, & Zip Code):

7. Name of Patient if not Employee:	8. Patient's Date of Birth:

9. Patient's Relationship to Employee:	10. If Child, indicate: Male ☐ Female ☐	11. If Married, is Spouse Employed: Yes ☐ No ☐	12. If yes, Spouse's Social Security Number:

13. Spouse's Employer:	14. Address (Street, City, State & Zip Code):

15. Is the patient covered by any other group insurance or health service plan? Yes ☐ No ☐	16. If yes, provide Policy Number:	17. Name of Other Plan:

18. Address of Other Plan (Street, City, State & Zip Code):

19. Do you have Medicare Insurance?

Part A: Yes ☐ No ☐
Part B: Yes ☐ No ☐

Effective Date: ____________________

20. Does your spouse or any of your children have Medicare Insurance?

Part A: Yes ☐ No ☐
Part B: Yes ☐ No ☐

Name: ______________________________

Effective Date: ______________________________

21. Is patient's condition due to any accident, injury, or illness arising out of employment?

Yes ☐ No ☐

22. If answer to #21 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 ☐

23. Is patient's condition due to an accident, injury, or illness caused by some other party?

Yes ☐ No ☐

24. If answer to #23 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 ☐

25. Is patient's condition due to an accident?

Yes ☐ No ☐

26. If answer to #25 is yes, how, when (date), and where?

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 as is required to properly pay all benefits due me or my dependents:

Employee Signature: ______________________________ Date: ____________________

PAY TO PROVIDER *(Optional)*

If you want benefits paid to the provider of care, this section must be signed and dated by the employee:

Employee Signature: ______________________________ Date: ____________________

ILWU-PMA WELFARE PLAN

Hospital, Medical, and Surgical Benefits Claim Form

PART 2 – PHYSICIAN STATEMENT

1. Patient's Full Name: ______________________________

2. Diagnosis: ______________________________

   (a) Is patient's condition due to accident? Yes ☐ No ☐ If yes, give date: ______________
   (b) Is patient's condition due to an accident, injury or illness out of employment? Yes ☐ No ☐
   (c) Is patient's condition due to an accident, injury or illness caused by some other party? Yes ☐ No ☐

3. Date patient first treated for present disability: ______________________________

4. Is treatment continuing? Yes ☐ No ☐

5. Surgical procedure performed: ______________________________ Date: ______________

   ______________________________ Date: ______________

6. Confined Hospital Name: ______________________ From: ____________ To: ____________

7. Is patient disabled (unable to perform usual activities)? Yes ☐ No ☐
   If yes, give date: From: ______________ To: ______________

8. Please attach itemized Bill. In lieu of itemized Bill, itemize Charges below:

DATE AND PLACE Home Hospital Office	NATURE OF SERVICES	CPT NUMBER	YOUR CHARGE TO PATIENT
			$
			$
			$
			$

9. To your knowledge, does patient have other Health Insurance or Health Service Plan Coverage?
   Yes ☐ No ☐ If yes, please identify: ______________________________

Attending Physician: ______________________ M.D. Federal Tax Number: ______________
(Please Print Name)

Address: ______________________ Telephone Number: ______________
(Street)

____
(City) *(State)* *(Zip Code)*

Physician Signature: ______________________ Date: ______________

Please Return Completed Form to:

ILWU-PMA COASTWISE CLAIMS OFFICE
P.O. Box 429101
San Francisco, CA 94142