CLAIM STATEMENT

PLEASE PRINT INFORMATION AND RETURN TO:

SEIU Local 1 & Participating Employers Health Trust

CLAIM DEPARTMENT

200 EAST RANDOLPH STREET * SUITE 1500 • CHICAGO, ILLINOIS 60601 • TELEPHONE (312) 233-8899

This form must be completed in **full** for each new claim filed with this office. Upon completion, please attach your bills to it and return to us.

PART I—TO BE COMPLETED BY EMPLOYEE

Employee's Name:_____ Area code_____ Phone No._____

Home Address:_____ City_____ State_____ Zip_____

SSN or **Alternate Identification #:**_____ **Birth Date**_____ **Sex**_____

Employer:_____ Phone No._____

Address:_____ City_____ State_____ Zip_____

Patient Information

Self_____

Spouse_____

Child_____

Patient's Name Date of Birth Sex

IMPORTANT — THIS SECTION MUST BE COMPLETED — FAILURE TO COMPLETE THIS SECTION WILL ONLY DELAY THE PROCESSING OF THIS CLAIM.

Spouse's Name:_____ Date of birth_____

Does your spouse have insurance through his or her employer? ❑ Yes ❑ No

If yes, coverage effective date_____

Name of employer sponsoring other insurance_____

Name of employee belonging to other group_____

Group Policy No. and/or Subscriber No._____

Full name and phone number of the other insurance:_____

(If the above answered YES please be sure to send copies of the same bills to the other company.)

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete.

Employee Signature:_____ Date_____

CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

All benefits provided under this Plan are automatically assigned to the provider of service unless a paid in full receipt is furnished to the Claim Office when a Claim is made.