Forward your itemized bill directly to:
IRON WORKERS BENEFIT TRUST
MAIN P.O. BOX 398
DAYTON, OHIO 45401-0398
® 26

MEDICAL / SURGICAL CLAIM FORM

Please indicate the year this claim form is for _____

Insurance Verification:
Dayton 1-937-454-1744
Toll Free 1-800-331-4277
(7:30 a.m. to 4:30 p.m.)

This form must be completed (#1-22) in full & signed by the member. A separate form is required for each family member.

1. IRON WORKERS NAME (First name, middle initial, last name).	2. I.W. SOCIAL SECURITY #	3. I.W. BIRTH DATE	4. I.W. MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
5. IRON WORKERS ADDRESS (Street, City, State, ZIP code).	6. HOME PHONE	7. SPOUSE'S BIRTH DATE	
	8. WORK PHONE	9. LOCAL UNION #	10. PATIENT'S RELATIONSHIP TO I.W. self ☐ spouse ☐ child ☐ other ☐
11. PATIENT'S NAME (First name, middle initial, last name).	12. PATIENT'S SOCIAL SECURITY #	13. PATIENT'S SEX ☐ MALE ☐ FEMALE	14. PATIENT'S DATE OF BIRTH / AGE
		16. NAME OF PATIENT'S FAMILY PHYSICIAN:	

17. IS SPOUSE EMPLOYED? (IF "YES", GIVE NAME, ADDRESS AND TELEPHONE # OF EMPLOYER) (IF "NO", GIVE NAME AND LOCATION OF LAST EMPLOYER AND DATE LAST WORKED).
☐ YES ☐ NO

18. IS PATIENT COVERED BY ANOTHER GROUP COVERAGE? ☐ YES ☐ NO **if YES, please answer these questions:**

Policyholders name: _____
Address _____
_____
Telephone # _____

Effective date of coverage _____
Policyholder's Date of Birth _____
Policyholder's ID # _____
Group ID # _____

Does this policy cover: (circle)

Medical	Yes	No
Dental	Yes	No
Vision	Yes	No
RX Card	Yes	No
Birthday Rule	Yes	No
Gender Rule	Yes	No

Insurance Company's Name, Address & Telephone No. _____

19. IS THE PATIENT ELIGIBLE FOR MEDICARE COVERAGE? ☐ YES ☐ NO **if YES, effective date of Medicare** _____

IF MEDICARE BENEFITS ARE AVAILABLE TO THE PATIENT, THEY MUST BE USED.

IS THE PATIENT ELIGIBLE FOR SOCIAL SECURITY? ☐ YES ☐ NO **if YES, effective date of Social Security** _____

20. IS THIS CONDITION RELATED TO PATIENT'S EMPLOYMENT? (Not Wear & Tear) (Past or Present) ☐ YES ☐ NO **if YES, please answer the following:**

Name, address & telephone # of employer (at time of injury / illness): _____
_____
Was this injury / illness reported to the employer? ☐ YES ☐ NO **if NO, please explain why:** _____
_____
Has this claim been filed with Worker's Compensation? ☐ YES (Claim # _____) ☐ NO
If YES please give name, address & telephone # of employer's Worker's Compensation carrier: _____
_____
If NO, please explain why: _____
Is this injury / illness related to a previous claim settled? ☐ YES ☐ NO (Attach copy of Worker's Compensation settlement or award)
Have you consulted an attorney to represent you in this matter? ☐ YES ☐ NO
Attorney's name, address & telephone # _____

21. IS THIS CLAIM A RESULT OF AN ACCIDENT OR INJURY? (Past or Present) ☐ YES ☐ NO **if YES, please refer to back of form***

22. I authorize release of any information pertaining to this claim. I certify that all information given is true and correct to the best of my knowledge.

_____ _____
IRONWORKER'S SIGNATURE **DATE**

ANY PERSON, WHO WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

ALL ACCIDENTS / INJURIES INCURRED OUTSIDE OF THE MEMBER'S HOME OR PROPERTY MUST HAVE THE BACK OF THIS FORM COMPLETED

*** IF YES TO #21, MEMBER *MUST* COMPLETE THIS SECTION *IN FULL*.**

Date and time of injury _____

Where did the accident occur (i.e, auto, shopping mall, home)? _____

Describe what happened in detail, including what injuries resulted from this accident. _____

If this was a MOTOR VEHICLE ACCIDENT:

Name and address of the driver: _____

Name and address of other driver: _____

Name and address of person cited for accident: _____

Name, address & telephone # of your auto insurance company: _____

Name, address & telephone # of other driver's auto insurance company: _____

If this was a NON-MOTOR VEHICLE ACCIDENT:

Name, address & telephone # of homeowner, business owner or other party responsible for accident: _____

_____

Name, address & telephone # of their insurance company: _____

Have you consulted an attorney to represent you in this matter? ☐ YES ☐ NO

Attorney's name, address & telephone # _____

ALL ACCIDENTS/INJURIES INCURRED OUTSIDE OF THE MEMBER'S HOME OR PROPERTY *MUST* HAVE THIS PORTION COMPLETED IN FULL AND SIGNED *BY THE MEMBER.*

Your Benefit Trust was created to provide you and your dependents with medical care and to relieve you of the burden of paying for it. However, cost for providing hospitalization and medical care has risen so drastically that your Board of Trustees has adopted a policy requiring reimbursement to the Benefit Trust for any claims paid on your behalf if a third party is found to be liable and makes or will make payment and/or settlement on those claims. The Benefit Trust is not interested in depriving you of any rights you may have against such third party and is prepared to cooperate with you and any attorney you may wish to retain in enforcing your claim. YOU ARE NOT REQUIRED TO FILE A CLAIM AGAINST THE THIRD PARTY, however, it is necessary to carry out the rules of your plan of benefits.

All accidents/injuries sustained outside of your home or personal property **must** have this subrogation agreement signed by the member and filed with the Trust Office prior to claims processing. Upon receipt of the executed agreement and accident information, we will process your claims based on Plan guidelines. If it should develop that you have no claim against or that the claim cannot be enforced against the third party, for any reason, no effort will be made to seek reimbursement from you.

SUBROGATION AGREEMENT

A. To the extent the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust, herein referred to as the Trust, shall have paid any money to or on behalf of participant, pursuant to the provisions of the plan of benefits provided by the Trust, because of loss or damage for which the employee may have cause of action against a third party who caused this loss or damage, this Trust shall be subrogated to the extent of such payment to any and all recovery as a condition of the payment of such money by the Trust.

B. In consideration of the payment, the undersigned participant does hereby assign and subrogate to the Trust all of the rights, claims, interests or things in action and action at law, to the extent of the amounts paid by the Trust which the undersigned may have against any party, person, firm or corporation, private or public, who may be liable, or may hereafter be adjudged liable, for the loss and the undersigned authorizes and empowers the Trust to sue, compromise or settle in the name of the undersigned, or of the beneficiary for the undersigned, and said Trust is hereby fully substituted in the place of the undersigned and subrogated to all of the rights of the undersigned in the premises for the amount paid by the Trust.

The undersigned further agrees that the undersigned will execute any and all appeal bonds or other instruments in writing pertaining to any litigation arising out of losses above referred to at the request of the Trust's representatives.

_____ _____

Member's Signature Witness Signature

_____ _____

Date Date

Rev. 11-99