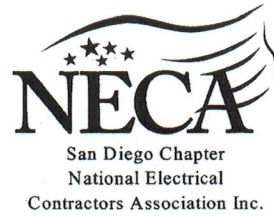




**SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST**  
 P.O. Box 231219  
 SAN DIEGO, CA 92193-1219  
 (858) 569-6322 or (800) 632-2569  
 Last Names: (A-F) ext 306, (G-K) ext 307, (L-R) ext 309, (S-Z) ext 308



**MEDICAL CLAIM FORM**  
**(MUST COMPLETE BOTH SIDES)**

Please complete a separate form for each family member for whom a claim is being made. If the patient has other primary coverage, please attach a copy of the Explanation of Benefits and any itemized bills relating to this claim.

<b>Participant's Name:</b>  <b>Street Address:</b>  <b>City, State &amp; Zip Code:</b>  <b>Telephone Number: (    )</b>	<b>Participant's Social Security Number (Last 4 Digits):</b>  <b>Participant:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female  <b>Marital Status:</b> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>  <b>Name &amp; Address of Current Employer:</b>  <b>Date of Last Hours Worked for this Employer:</b>	
<b>Name of Spouse/Domestic Partner</b>	<b>Spouse's/Domestic Partner's Birth Date (MM/DD/YY)</b>	<b>Spouse's/Domestic Partner's Social Security Number (Last 4 Digits)</b>

Was the participant's spouse/domestic partner or dependent employed in the last 12 months?  Yes  No If yes, please complete the following:

Spouse/Domestic Partner or Dependent's Name	Employer's Name	Employer's Home Office Address	Employer's Telephone Number

1. Does the participant's spouse/domestic partner or other family member have group medical insurance available through employment or any other source? If yes, please provide the information on the bottom of this page.  YES  NO
    - a. Is the spouse/domestic partner or family member covered by group coverage through his/her employment?  YES  NO
    - b. Is coverage provided only for the spouse/domestic partner or family member?  YES  NO
    - c. Is this coverage provided at no cost?  YES  NO
    - d. Is coverage available but was waived or declined?  YES  NO

If Yes to #1d, did he/she receive any compensation or benefit from their Employer for doing so?  YES  NO

  - e. Date of the group's last open-enrollment period: \_\_\_\_\_ Effective Date of Coverage selection: \_\_\_\_\_
2. Does the participant's spouse/domestic partner or child have Medicare or Federal/State Government Insurance?  YES  NO
3. If this claim is for a dependent child under the age 26, is this child a natural child, stepchild, legally adopted child, foster child or a child under legal guardianship?  YES  NO
4. If the child is a stepchild, legally adopted child, foster child or under legal guardianship, the Trust Office must have sufficient documentation to verify this relationship to the participant before any claim payment(s) may be made.

<u>Name of Insured Person</u>	<u>Insurance Company</u>	<u>Address</u>	<u>Telephone</u>	<u>Policy or Group Number</u>
_____	_____	_____	(    ) _____	_____

**PLEASE COMPLETE THE BACK OF THIS FORM**

**Patient Information:(MUST BE COMPLETED)**

Patient's Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Birth Date (MM/DD/YY)	Patient's Social Security No. (Last 4 Digits)
----------------	--	------------------------------------	--

1. Nature of Illness & Treatment: \_\_\_\_\_

2 Name of Physician: \_\_\_\_\_

3. Was this medical condition the result of an accidental injury?  YES  NO

If yes, on what date did this accidental injury occur? \_\_\_\_\_

If yes, was the accidental injury due to playing sports or the fault/negligence of a third party?  YES  NO

If yes, do you have insurance to cover this injury?  YES  NO

If yes, what is the name and address of the Insurance Company covering this claim:

\_\_\_\_\_

\_\_\_\_\_

Was the accidental injury the result of an auto accident?  YES  NO

If this was an off-road vehicle, do you carry medical insurance for it?  YES  NO

If yes, what is the name and address of the Insurance Company covering this claim:

\_\_\_\_\_

\_\_\_\_\_

4. Was the condition or accidental injury job related?  YES  NO

If yes, have you filed a Workers' Compensation Claim?  YES  NO

If yes to #3 or #4, describe in detail how & where the accidental injury occurred:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL RECORDS:** I hereby certify under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, insurance company or organization to release any information including full copies of their records for any medical treatment, services or benefits rendered or payable to me (or my dependents). Recognizing that my entitlement to benefits under the Plan may not be assigned to any provider of Surgical/Medical services I hereby authorize payment of eligible expenses directly to the provider, if any, otherwise payable to me for services, but not to exceed the maximum allowance for those services provided in the Plan Document. A copy of this authorization shall be as valid as the original.

Participant or Spouse's Signature: \_\_\_\_\_  
(If patient is a minor, a parent's signature is required)

Date: \_\_\_\_\_

**\*\*\*\*AN INCOMPLETE FORM WILL RESULT IN A DELAY IN PROCESSING YOUR CLAIM\*\*\*\***