SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST
PO BOX 231219, SAN DIEGO, CA 92193-1219

(858) 569-6322 or (800) 632-2569
Ext 225 (A-F), Ext 226 (G-O), Ext 224 (P-Z)

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.

Participant's Name:	**Participant's Social Security Number:**
Street Address:	**Participant: ☐ Male ☐ Female Marital Status: M ☐ S ☐ D ☐ W ☐**
City, State & Zip Code:	**Name & Address of Current Employer:**
Telephone Number: ( )	**Date of Last Hours Worked for this Employer:**

Name of Spouse/Domestic Partner	Spouse's/Domestic Partner's Birth Date (MM/DD/YY)	Spouse's/Domestic Partner's Social Security Number

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? **☐ 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 other 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**

   a. 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.

Name of Insured Person	Insurance Company	Address	Telephone	Policy or Group Number
_____	_____	_____	( ) _____	_____

PLEASE COMPLETE THE BACK OF THIS FORM

Patient Information: (MUST BE COMPLETED)

Patient's Name	☐ Male ☐ Female	Patient's Birth Date (MM/DD/YY)	Patient's Social Security No.

1. Nature of Illness & Treatment: _____

_____

2. Name of Physician: _____
3. Has the patient been treated for the same condition within the last 24 months? ☐ YES ☐ NO

   If yes, what is the treating physician's name & telephone number:

   _____

   _____

   When was the patient last treated for this condition? _____
4. 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 the fault/negligence of a third party? ☐ YES ☐ NO
- Was the accidental injury the result of an auto accident? ☐ YES ☐ NO

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

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

If yes to #4 or #5, describe in detail how & where the accidental injury occured: _____

_____

_____

_____

_____

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). I also hereby authorize payment directly to the provider for Surgical/Medical benefits, 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: _____ Date: _____

(If patient is a minor, a parent's signature is required)

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