IBEW LOCAL 569

SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST
4545 VIEWRIDGE AVENUE, SUITE 110
SAN DIEGO, CA 92123-5615
(858) 569-6322 or (800) 632-2569
Last Names: (A-F) ext 306, (G-K) ext 312, (L-R) ext 309, (S-Z) ext 308

San Diego Chapter
National Electrical
Contractors Association Inc.

MEDICAL CLAIM FORM

Please ensure that this entire claim form has been properly completed and signed prior to submitting it to the Trust Office.

Employee Name: _____

Employee Social Security Number (Last 4 Digits): _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Patient's Name: _____

Patient's Social Security Number (last 4 Digits): _____ DOB: _____

Relationship with Employee (Please Circle): Self Spouse Domestic Partner Dependent Child

Nature of Injury: _____

Physician or Clinic Name: _____ Date of Injury: _____

Describe in detail how the injury occurred:

_____

_____

1. Was this injury a result of a work-related injury? ☐ Yes ☐ No
   If yes, have you filed a Workers' Compensation Claim? ☐ Yes ☐ No
2. Was this injury due to the negligence or fault of a third party? ☐ Yes ☐ No
3. Did this injury occur during the participation of a school or an organized sport? ☐ Yes ☐ No
   If yes, do you have a student accident or organized team sports insurance to cover this injury? ☐ Yes ☐ No
   If yes, what is the name and contact information of the insurance company covering this claim:

_____

_____

4. Was the injury the result of an automobile or motorcycle accident? ☐ Yes ☐ No
   If yes, what is the name and contact information of the auto insurance company covering this claim?

_____

_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby certify under the 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).

Patient Signature: _____ Date: _____
(If patient is a minor, a parent's signature is required.)

If <u>any part</u> is left incomplete, the Trust Office will send the form back to you and any claims payments will be left on hold.