RETURN THIS FORM TO:

UNITED FOOD & COMMERCIAL WORKERS UNION-EMPLOYER HEALTH & WELFARE FUND
P.O. Box 470846 • Broadview Heights, Ohio 44147
Telephone (216) 241-2828 WATS 1-800-241-2828

TO AVOID UNDUE DELAY COMPLETE ALL REQUIRED AREAS OF INFORMATION. YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETED IN FULL.

RETURN IMMEDIATELY

MetroHealth Select
STATEMENT OF CLAIM
HOSPITAL-SURGICAL-MEDICAL

Completed Form Can Be emailed to:
hwforms@ufcw880funds.com

1. TO BE COMPLETED BY EMPLOYEE

please print member's last name | first | middle

home address

city – state – zip code

date of birth | sex | home phone number | cell phone number

email address

occupation | local no. | social security number

	YES	NO	
2.	☐	☒	IS THIS A DEPENDENT CLAIM? IF SO, PLEASE COMPLETE **2a.**
			MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOW/WIDOWER ☐ DIVORCED
3.	☒	☐	ARE YOU MARRIED? IF SO PLEASE COMPLETE **3a**.
4.	☐	☒	WAS THIS DISABILITY DUE TO AN ACCIDENT OR INJURY? IF SO, PLEASE COMPLETE **4a.**
5.	☐	☒	IS ILLNESS OR INJURY DUE TO CLAIMANT'S OCCUPATION?
6.	☐	☒	ARE YOU WORKING FOR ANOTHER EMPLOYER? IF YES, PLEASE PROVIDE NAME AND ADDRESS OF OTHER EMPLOYER.

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

The above answers are true and correct to the best of my knowledge.

7. _____
EMPLOYEE'S SIGNATURE **DATE**

8. _____
spouse's signature | date

2a. NAME OF PATIENT
(if other than employee)

full name of dependent

date of birth | sex | relationship

social security number of patient

name of dependent employer

address of dependent employer

city | state | zip code

name of policy holder | **name of insurance co. plan**

policy number | **effective date**

3a. COMPLETE IF MARRIED OR COVERED UNDER ANY OTHER PLAN

name of spouse | date of birth

spouse's social security number

name of spouse's employer

address of spouse's employer

city | state | zip code

name of policy holder | name of insurance co. plan

policy number | effective date

4a. PLEASE DESCRIBE ACCIDENT OR INJURY

date of injury | hour (am-pm) | where did injury occur?

DESCRIBE DISABILITY/CIRCUMSTANCES: _____

INSURED AND PATIENT MUST SIGN CONSENT TO RELEASE INFORMATION ON REVERSE SIDE OF FORM.

[092616]

HEALTH INSURANCE CLAIM FORM

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

CONSENT FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to UFCW Union-Employer Health & Welfare Fund or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by UFCW Union-Employer Health & Welfare Fund or its authorized claims-paying administrator to determine eligibility for benefits or services under the Benefit Plan. Any information obtained will not be released by UFCW Union-Employer Health & Welfare Fund to any person or organization EXCEPT to re-insuring companies, the Medical Information Bureau, Inc., employer, contract holder, or other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below.

Date	Member's Signature	Patient's Signature (if other than a minor child)

PATIENT & EMPLOYEE INFORMATION		
PATIENT'S NAME *(First name, middle initial, last name)*		PATIENT'S DATE OF BIRTH
MEMBER'S NAME *(First name, middle initial, last name)*	*I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW* SIGNED *(Member or Authorized Person)*	