

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.**

