REGIONAL DISTRICT COUNCIL
WELFARE TRUST
333 Pierce Rd. Suite 410
Itasca, Illinois 60143
Telephone 847-463-8840

IMPORTANT

MEDICAL CLAIM STATEMENT
EMPLOYEE'S STATEMENT

Please submit all Medical / Dental claims To:
Regional District Council
William C. Earhart Co, Inc.
PO Box 4148
Portland, OR 97208
1-800-846-0611

1. Employee's Name _____ Social Security No._____ Date of Birth_____

Home Address_____ Local Union #_____

_____
(CITY) (STATE) (ZIP)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Employer's Name_____

Address_____

2. This claim is for ☐ Spouse ☐ Unmarried Son ☐ Unmarried Daughter
☐ Other, explain_____
Name of Dependent_____ Date of Birth_____
Dependents Occupation, if any_____/ Social Security #_____
Is Dependent child a full-time student ? ☐ Yes ☐ No - If yes and over age 18 indicate:

Name of School_____

Address_____

3. Claim is for ☐ An Accident ☐ A sickness
Briefly describer (for example: heart, pregnancy, fall, etc.)_____

_____

COMPLETE IF CLAIM IS FOR AN ACCIDENT

Date/Time_____ Where _____How_____

4. Did sickness or injury arise out of or in the course of any employment? ☐ Yes ☐ No

5. Name and address of spouse's Employer_____

6. Are you or your dependents entitled to benefits from any other group Insurance plan including Blue Cross, Blue Shield, or governmental programs including Medicare ? ☐ Yes ☐ No

A. IDENTIFY FAMILY MEMBER INSURED UNDER OTHER PLAN
B. NAME(S) AND ADDRESS OF OTHER INSURANCE COMPANY AND/OR ORGANIZATION
C. GROUP POLICY NUMBER

I authorize any physician, hospital, insurer or any other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to this fund or their duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective as and valid as the original .

Employee's Signature _____Date_____

PATIENTS SIGNATURE — Such information may be used to the extent deemed necessary to determine the validity or amount payable in regard to this claim

(Parent if patient is a minor)_____Date_____