MEDICAL CLAIM FORM

PLUMBERS AND FITTERS LOCAL 101
HEALTH AND WELFARE FUND

All Claims Should be Mailed to:
J.W. Terrill Benefit Administrators
PO Box 6877
Chesterfield, MO 63006
800-467-5982 (fax: 314 594 2599)

PART 1: MUST BE COMPLETED BY PARTICIPANT

Participant's Name:	Participant's Identification No.	Participant's Birth Date:
Home Address:		Home Phone No:

City	State	Zip Code	

☐ Please check this box if the address you entered is a new address

Patient's Name (If other than Participant):	Patient Relationship to Participant:	Male ☐ Female ☐
Patient's Birth Date:	Is Patient Eligible for any other Group Health Plan? Yes ☐ No ☐	Is Patient Employed? Yes ☐ No ☐
Name and Address of Patient's Employer:		

Nature of Sickness, Injury, Reason why treatment was sought:

Date Accident or Sickness Began:	Date Admitted if hospitalized:

If Injured, How, When and Where Did Accident Happen?	Automobile Accident? Yes ☐ No ☐

If an Injury, was a Third Party at Fault? Yes ☐ No ☐	Name of Third Party?	Address of Third Party:
Name and Address of Third Party's Insurance:		Third Party's Phone Number:
Is Claim Due To An On-The-Job Illness or Injury? Yes ☐ No ☐	Have you filed a Claim with Workers' Compensation? Yes ☐ No ☐	Physician's Name:
Name of Spouse:		Name and Address of Spouse's Employer:

Is the patient covered under any other Group Plan, Health Maintenance Organization, Government Plan or Insurance Policy which would cover any of the expenses of this Claim? Yes ☐ No ☐ If yes, give name, address and policy number of plan providing benefits.
Plan Name And Address: Policy No.

PATIENT OR PARENT PLEASE SIGN BELOW
Certification and Permission to Release Information: I hereby certify that the above information is true and correct to the best of my knowledge; I understand that falsification or withholding of material facts may result in loss of benefits and other serious consequences.
For the purposes of determining eligibility for benefits and claim processing, I hereby permit J.W. Terrill to receive from and provide to medical practitioners, medical-related facilities, insurance companies, other health plans and other parties involved in claims processing information as to any physical or mental condition of myself or my covered dependents. I know that I have a right to receive a copy of this agreement and I grant that a photocopy is as valid as the original.

____ **Date:**____________________
Patient or Parent if Minor