2200 Professional Drive, Suite 200 · Roseville, CA 95661
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

CLAIM STATEMENT – MEDICAL BENEFITS

In consideration of the payment of benefits by the Trust Fund relating to the illness or injury on which this claim is based it is understood that the undersigned member and/or his dependents will be required in order to receive benefits from the Trust to execute an assignment to the Trust as required by its Rules if the employee and/or his dependents recovers any amount by judgment compromise or settlement from any third party who may be liable for such illness or injury.

PART I: TO BE COMPLETED BY THE EMPLOYEE ONLY

1. MEMBER'S NAME: _____ _____
(LAST) (FIRST) (MIDDLE) SSN OR ID#

2. NAME OF PATIENT: _____ _____
(LAST) (FIRST) (MIDDLE) DATE OF BIRTH

TO BE COMPLETED IF PATIENT IS INJURED

3. WHERE DID THE INJURY OCCUR? _____ DATE & TIME: _____

4. DESCRIBE HOW IT HAPPENED: _____

TO BE COMPLETED IF WORK RELATED INJURY OR ILLNESS

5. IS PATIENT'S CONDITION DUE TO INJURY OR ILLNESS WHICH OCCURRED ON THE JOB? ☐ YES ☐ NO

   IF YES, DESCRIBE INJURY OR ILLNESS CAUSED BY EMPLOYMENT: _____

   _____

6. HAVE YOU FILED A CLAIM FOR WORKER'S COMPENSATION FOR THIS DISABILITY? ☐ YES ☐ NO

   IF NO, PLEASE EXPLAIN: _____

   _____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER'S SIGNATURE: _____ DATE: _____

(SEE REVERSE SIDE FOR PHYSICIAN'S STATEMENT & ASSIGNMENT OF BENEFITS)

PART II ATTENDING PHYSICIAN'S STATEMENT

1. PATIENT'S NAME: _____ _____
(LAST) (FIRST) DATE OF BIRTH

2. NATURE OF SICKNESS/INJURY OR DIAGNOSIS CODE (DESCRIBE COMPLICATION IF ANY): _____

_____

3. DID THIS SICKNESS OR INJURY ARISE OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

4. PLACE OF SERVICE: ☐ OFFICE ☐ INPATIENT HOSPITAL ☐ OUTPATIENT HOSPITAL ☐ HOME

DATES OF SERVICE (MM/DD/YYYY) FROM:	TO:	PROCEDURE CODE	DESCRIPTION	NUMBER OF UNITS	CHARGE
/ /	/ /				.
/ /	/ /				.
/ /	/ /				.
/ /	/ /				.

ATTENDING PHYSICIAN'S NAME: _____ _____
PLEASE PRINT (LAST) (FIRST) (MIDDLE) DEGREE

FEDERAL TAX ID NUMBER: _____ PHONE NUMBER: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

ATTENDING PHYSICIAN'S SIGNATURE: _____ DATE: _____
(MM/DD/YYYY)

PART III: **PARTICIPANT'S ASSIGNMENT** **(READ BEFORE SIGNING)**	**TO BE COMPLETED AND SIGNED BY THE MEMBER IF DIRECT PAYMENT OF BENEFITS TO THE PROVIDER OF SERVICE IS DESIRED. THIS ASSIGNMENT WILL NOT BE HONORED IF SIGNED BY A DEPENDENT OR PERSON OTHER THAN THE MEMBER. PERSONAL DATED SIGNATURE OF MEMBER IS REQUIRED IN ORDER TO ASSIGN BENEFITS.** **I hereby assign benefits to the physician indicated hereon which are payable as a result of this claim as established herein or by statement attached.** SIGNATURE: _____ DATE: _____