AUTOMOBILE MECHANICS' LOCAL 701 WELFARE FUND

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527
TELEPHONE: (708) 482-0110 | TOLL FREE: (800) 704-6270 | FAX: (708) 482-9140

☐ **Please check if your address has changed since your last claim**

PLEASE ANSWER ALL QUESTIONS FULLY AND COMPLETE ALL SECTIONS

PART A - TO BE COMPLETED BY THE EMPLOYEE-MEMBER

YOUR FULL NAME (EMPLOYEE-MEMBER)	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED	☐ MALE ☐ FEMALE	ID # / SSN # ____________ DATE OF BIRTH ____/____/____
YOUR HOME ADDRESS (NO. & STREET) (CITY) (STATE) (ZIP CODE)			

COMPLETE THIS SECTION ONLY IF CLAIM IS FOR DEPENDENT

DEPENDENT'S LAST NAME	FIRST NAME	RELATIONSHIP	DEPENDENT'S DATE OF BIRTH / /
ADDRESS (IF DIFFERENT FROM MEMBER)			IF CHILD, IS CHILD MARRIED? ☐ YES ☐ NO
IF CHILD, IS CHILD WORKING? ☐ YES ☐ NO	NAME, ADDRESS AND PHONE NUMBER OF EMPLOYER		

INFORMATION ABOUT MEMBER'S SPOUSE OR OTHER PARENT OF DEPENDENT CHILD **(THIS BOX MUST BE COMPLETED FOR ALL CLAIMS)**

NAME OF SPOUSE OR PARENT (other than Member)		IS SPOUSE OR PARENT EMPLOYED? ☐ YES ☐ NO
NAME OF SPOUSE'S OR PARENT'S EMPLOYER (other than Member)	SPOUSE'S OR PARENT'S DATE OF BIRTH	UNION AFFILIATION
ADDRESS OF SPOUSE'S OR PARENT'S EMPLOYER (other than Member)	TELEPHONE NUMBER	EMPLOYMENT DATE

ARE YOU OR YOUR DEPENDENT INSURED OR COVERED UNDER ANY OTHER GROUP INSURANCE OR WELFARE PLAN THROUGH ANY EMPLOYER OR LABOR ORGANIZATION?
❐ YES ❐ NO **IF YES, GIVE NAME AND ADDRESS, AND POLICY NUMBER, OR INSURANCE COMPANY OR PLAN OFFICE PROVIDING BENEFITS.**

NAME OF COMPANY	POLICY HOLDER NAME
ADDRESS	POLICY NO. / ID NO.
	PHONE NO.

LIST ALL PERSONS COVERED BY THE OTHER PLAN	OTHER PLAN COVERS (CHECK ALL THAT APPLY)
____________________	❑ MEDICAL – EFF. DATE ___/___/___
____________________	❑ DENTAL – EFF. DATE ___/___/___
____________________	❑ VISION – EFF. DATE ___/___/___
____________________	❑ PRESCRIPTION DRUG – EFF. DATE ___/___/___
____________________	

BOTH EMPLOYEE AND SPOUSE MUST SIGN

I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any physician, medical examiner or practition, coroner, hospital, veterans administration Hospital, clinic, other medical or medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured of the family members for which claim is made, to give to AUTOMOBILE MECHANICS LOCAL NO. 701 UNION AND INDUSTRY WELFARE FUND or its legal respresentative, any and all such information a photocopy of this authorization shall be as valid as the original.

Date claim signed ____________ Signature ____________ Employee sign here

Phone (   ) ____________ Signature ____________ Spouse sign here

PLEASE COMPLETE REVERSE SIDE IF INFORMATION IS RELATED TO A SPECIFIC CLAIM

FORM 701 AM

Automobile Mechanics' Local 701 Welfare Fund

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527
TELEPHONE: (708) 482-0110 | TOLL FREE: (800) 704-6270 | FAX: (708) 482-9140

MEMBER ____

ID# ____

PATIENT ____

SERVICE DATE ____

PATIENT DOB____

CLAIM ____

We have received a claim for treatment that may be the result of an accident or injury. Please provide the information requested below in regard to the claim in question. **Please be as specific as possible in answering. Failure to respond completely may result in a delay in claim processing.**

Please explain below why the patient sought medical attention.

____

____

Is this condition a result of the patient's employment? Yes_____ No_____

Is the condition being treated the result of an: Illness_____ Accident/Injury_____

If an accident/injury:

What was the date the accident/injury occurred? _____/_____/________

How did the accident/injury occur?____

____

Do you feel that another party is responsible for this accident/injury? Yes_____ No_____

If yes, please provide a description of that party's involvement in the accident/injury.________________

____

____

Are you pursuing reimbursement from any other party or insurance carrier in relation to this condition? Yes_____ No_____

Member Signature:____ Date:_____/_____/________