

MECHANICS' LOCAL 701 WELFARE FUND

500 W. Plainfield Road • Countryside, IL 60525

TEL (708) 482-0110 • 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)		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
		ID #/SS # _____	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? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF CHILD, IS CHILD WORKING? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> MEDICAL – EFF. DATE ____/____/____ <input type="checkbox"/> DENTAL – EFF. DATE ____/____/____ <input type="checkbox"/> VISION – EFF. DATE ____/____/____ <input type="checkbox"/> PRESCRIPTION DRUG – EFF. DATE ____/____/____
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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 practitioner, 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 representative, 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

