

# MIDWEST OPERATING ENGINEERS WELFARE FUND

6150 Joliet Road  
Countryside, Illinois 60525  
(708) 482-7300

Name of Member \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Social Security No. \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Employer Name \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## IF THIS CLAIM IS FOR YOUR DEPENDENT

Name of Dependent (First) \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Member Wife \_\_\_\_\_ Son \_\_\_\_\_ Daughter \_\_\_\_\_ Other \_\_\_\_\_

Is Dependent Employed? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Provide Employer Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

## IF YOU OR YOUR DEPENDENT HAVE ANY OTHER GROUP INSURANCE

Insured's Name \_\_\_\_\_

Type: Insurance \_\_\_\_\_ Medicare \_\_\_\_\_ Health Maintenance (HMO) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

## ABOUT THIS CLAIM

\* Describe sickness or injury \_\_\_\_\_

\* Was the condition the result of an accident or injury? Yes \_\_\_\_\_ No \_\_\_\_\_

\* If yes, tell us how and where (address) it happened \_\_\_\_\_

\* Date accident occurred or sickness began \_\_\_\_\_ Date first treated \_\_\_\_\_

\* Did condition occur in the course of employment? Yes \_\_\_\_\_ No \_\_\_\_\_

## MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release when requested by the Health and Welfare Fund, of any facts concerning the injury, illness, or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

X Member's Signature \_\_\_\_\_ Dated \_\_\_\_\_

I AUTHORIZE PAYMENT OF BENEFITS TO THE PROVIDER(S)

X Member's Signature \_\_\_\_\_

(Spouse cannot sign)