

PUGET SOUND ELECTRICAL WORKERS HEALTH AND WELFARE TRUST

EMPLOYEE STATEMENT											
<input type="checkbox"/> Check here if your address is new.											
PART 1 - EMPLOYEE INFORMATION											
EMPLOYEE'S NAME - First			Initial		Last		<input type="checkbox"/> M <input type="checkbox"/> F		EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE Mo. Day Year	
HOME ADDRESS		STREET			CITY		STATE		ZIP	PHONE	
EMPLOYED BY									LOCAL NO.		
PATIENT'S NAME - First			Initial		Last		<input type="checkbox"/> M <input type="checkbox"/> F		PATIENT SOCIAL SEC. NO.	PATIENT BIRTH DATE Mo. Day Year	RELATION TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
EMPLOYEE MARITAL STATUS		IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU				IF DEPENDENT CHILD IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT?					
<input type="checkbox"/> MARRIED <input type="checkbox"/> LEGAL SEP. <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> FOSTER CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> GUARDIANSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____				<input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF SCHOOL _____ IF "NO", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? <input type="checkbox"/> YES <input type="checkbox"/> NO					
NAME OF SPOUSE (if not patient listed above)						SPOUSE BIRTHDATE		SPOUSE SOCIAL SECURITY NO.			
IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME & ADDRESS SPOUSE'S EMPLOYER									
PART 2 - INSURANCE INFORMATION											
ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO											
IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER _____											
NAME OF SUBSCRIBER _____					SUBSCRIBER SOC. SEC. NO. _____						
OTHER GROUP PLAN COVERS: <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN OTHER GROUP PLAN POLICY OR I.D.# _____											
OTHER GROUP PLAN INCLUDES: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION NAME OF PERSON COVERED _____											
ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES MEDICARE EFFECTIVE DATE _____											
PART 3 - ACCIDENT/INJURY INFORMATION											
WAS CARE REQUIRED BECAUSE OF AN INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID ACCIDENT OCCUR WHILE AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO											
DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____											
HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", GIVE CLAIM NUMBER _____											
FOR TIME LOSS: LAST DAY WORKED _____ DATE RETURNED TO WORK _____											
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. Do not sign if bills have been paid.					I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original.						
Employee Signature _____ Date _____					Patient Signature (if not minor child) _____						
Employee Signature _____ Date _____					Employee Signature _____ Date _____						
PROCEDURE FOR FILING A CLAIM											
1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim. 2. Attach an itemized bill for all charges relating to this claim. If claim is for disability, a doctor MUST complete the "Attending Physician's Statement" on the reverse side of this form. 3. Complete a separate form for each patient. 4. Mail completed form and itemized bills to:											
P.S.E.W. TRUST P.O. Box 34970 Seattle, WA 98124-1970 Phone: (206) 441-7574 or 1-800-331-6158											
To insure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable. Prescription drugs must have actual pharmacy receipt showing: a) name of pharmacy; b) name of patient; c) date prescription is filled and d) name and cost of drug. A cash register receipt is NOT acceptable. If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching insurance or Medicare payment explanation.											

