INSTRUCTIONS:

1. Member's Statements (Section A and Section C) must be completed in detail and signed for all claims. Please give special attention to the Authorizations in Section C. the authorization to pay the physician is optional.
2. The attending Physician's Statement (Section D) must be completed by the physician and accompany all claims.

MAIL BOTH COPIES OF COMPLETED FORM TO:

IBEW Local Union #363
67 Commerce Drive South
Harriman, NY 10926

BENEFIT CLAIM REPORT

ATTACH ALL OTHER ITEMIZED STATEMENTS AND BILLS TO THIS FORM

Section A Member's Statement

NAME OF MEMBER	EMPLOYED BY	
HOME ADDRESS	MARITAL STATUS SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐	
CITY STATE ZIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH
(IF CLAIM FOR DEPENDANT) NAME OF DEPENDANT	RELATIONSHIP TO MEMBER	DATE OF BIRTH
IS PATIENT A FULL TIME STUDENT?	NAME OF SPOUSE'S EMPLOYER	
NAME & ADDRESS OF SCHOOL	ADDRESS OF SPOUSE'S EMPLOYER	

IF INJURED HOW AND WHERE DID ACCIDENT HAPPEN? IS CLAIM BEING MADE FOR WORKMEN'S COMP? YES ☐ NO ☐

ARE HOSPITAL SURGICAL OR MEDICAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER EMPLOYER UNION STUDENT ASSOCIATION GROUP PLAN OR GOVERNMENTAL PROGRAM APPLICABLE TO THIS CLAIM? YES ☐ NO☐

IF YES, INSERT NAME AND ADDRESS OF THE OTHER GROUP POLICY HOLDER AND INSURANCE COMPANY

NAME OF GROUP POLICY HOLDER POLICY NUMBER

ADDRESS OF GROUP POLICY HOLDER

NAME OF INSURANCE COMPANY PROVIDING BENEFITS	ADDRESS OF INSURANCE COMPANY PROVIDING BENEFITS

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT

MEMBER'S SIGNATURE _____ DATE COMPLETED _____

Section B Administrator's Statement

SIGNATURE OF OFFICIAL REPRESENTATIVE	DATE	EFFECTIVE DATE OF PATIENT'S COVERAGE	IF CANCELLED, DATE OF CANCELLATION

Section C To Be Completed By Patient (Member)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the resonable and customary charge for those services.	SIGNED MEMBER	DATE
AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	SIGNED PATIENT OR PARENT IF MINOR	DATE

Section D Attending Physician's Statement

PATIENT'S NAME

DIAGNOSIS AND CONCURRENT CONDITIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐

SUSTAINED IN AUTO ACCIDENT? YES ☐ NO ☐

REPORT OF SERVICES (or attach itemized bill)

DATE OF SERVICES	PROCEDURE CODE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES

DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY	TOTAL CHARGES $_____
TAXPAYER I.D. NUMBER	AMOUNT PAID $_____
THIS IS REQUIRED UNDER 6109 INTERNAL REVENUE SERVICE CODE AND APPLICABLE REGULATIONS THERETO	BALANCE DUE $_____

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE TELEPHONE