Public Employees Local 71 Trust Fund

Zenith American Solutions
PO Box 91013, Seattle, WA 98111-9103

☐ **Medical** ☐ **Dental Claim Form**
(Check box(es) to identify type of claim(s)

For benefit or eligibility information please call Zenith American Solutions at 1-800-557-8701-3671.

Instructions: Complete this form, attach all itemized bills, send to Zenith American Solutions at the address above, and keep a copy for your records.

Employee Information

Full Name:	Social Security or Tax ID Number:	
Mailing Address:		
City:	State:	Zip:

Patient Information

Full Name:	☐ Member ☐ Spouse ☐ Dependent Child
If Claim is for dependent child, indicate relationship: ☐ Child ☐ Step Child ☐ Legal Guardianship ☐ Other _____	
If Child is age 19 or older, is child a full-time or half-time student? ☐ Yes ☐ No	
If Yes, a current semester enrollment form must be on file. If No, does the child have a developmental disability, physical handicap, or live at home? ☐ Yes ☐ No	

Other Insurance Information

Does the patient have other health insurance coverage: ☐ Yes ☐ No	
If Yes, please provide the following information for each policy/plan: Insurance Company/Plan Administrator's Name, Address, Telephone No., Policy/Plan No., and types of coverage:	
1.	☐ Medical ☐ Dental
2.	☐ Medical ☐ Dental
Is spouse employed? ☐ Yes ☐ No If yes, please provide the name, address and telephone number of employer and/or local union:	

Claim Information (Complete only applicable information)

Are expenses related to an Accident? ☐ Yes ☐ No	If Yes, Date of Accident:
Type of Accident: **(If claim is related to an accident, you will receive an accident questionnaire. Please respond promptly to expedite claim processing.)** ☐ Automobile ☐ Home/Recreational ☐ Employment Related ☐ Other _____	
If Employment Related, please provide Name, Address, and Telephone Number of Employer:	
Briefly Describe Accident:	

Authorization to Process Claim

In order to process a claim for benefits, I authorize any physician, hospital or other medical/dental provider to release to Zenith American Solutions and the planholder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the claim. ***Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.***

I authorize benefit payment to the health provider for the services and or supplies described on this claim form. ☐ Yes ☐ No

Eligible Participant's Signature:	Date: