LABORERS' BENEFITS · ST. LOUIS

Medical Claims Injury and/or Illness Form

This form must be completed in its entirety.

Medical claims related to this injury/illness will remain denied until this form is returned.

Medical ID#: _____ or Last 4 of Member's SS#: xxx-xx-_____

Member Name: _____

Patient Name: _____

Address: _____

Phone: _____ E-mail Address: _____

Relationship to Member: O Self O Spouse O Dependent Child

1. Date of incident that resulted in your pain, illness, or injury: _____
   a. Area of the body affected by pain, illness, or injury: _____
   b. Did this illness or injury happen at work? O Yes O No
   c. How & where did the injury occur? _____
   d. Provide a detailed description of your pain, illness, or injury: _____

2. Are you still being treated for pain, illness, or injury? : O Yes O No

If your claim involves another person, private property, a motor vehicle, work related injury, league sponsored sport, or if a police report was taken, continue completing this form. If not, see the other side of this document for your signature.

3. Without regard to who may have been at fault in causing the illness or injury referred to above, do you have any other coverage for this illness or injury? O Yes O No
   a) Under another health insurance plan or policy? O Yes O No
      Under an automobile insurance policy, which includes medical payor no-fault provisions?
      If yes, attach the declarations page of the policy. O Yes O No
   b) Under a homeowner's policy? O Yes O No
      If yes, attach the declarations page of the policy
   c) Under a general liability or "umbrella" policy? O Yes O No
      If yes, attach the declarations page of the policy.
   d) Under a worker's compensation plan or policy? O Yes O No

If you answered yes to any of these questions, provide the following information:

Insurance Company or Benefit Provider: _____

Insurance Company or Benefit Provider Address: _____

Insurance Company or Benefit Provider Phone Number: _____

Name of subscriber: _____ Policy No: _____

Send us any correspondence to/from the other benefit providers or insurers.

See Reverse Side

2357 59th Street, St. Louis, MO 63110-2811 | Phone: 314.644.2777 | Fax: 314.644.6391
Email: claims@stllaborers.com

4. Have you received benefits, settlement, or other money from any of the sources you listed in answer to question one? O Yes O No

5. If yes, state forth the amount you received from each source.

_____

6. Police Department and Report Number: _____

Obtain a copy of the police report and send it with this form.

Name, addresses, and telephone numbers of any party or parties you feel were at fault in causing your injury. (If none, move on to question 8.)

Name: _____

Address: _____

Phone: (____) _____

7. Name, address, and telephone number of that party's insurance company:

Name: _____

Address: _____

Phone: (____) _____

Send us a copy of the claim or demand you have made against the responsible individual or that individual's insurer and, if available, any responses you have received to your claim or demand.

8. Have you received any money from the responsible third party or insurer for a third party? If yes, provide amounts received from each party or insurer. O Yes O No

_____

Have you signed the settlement document or release of liability with respect to the incident? If yes, attach a copy of each. O Yes O No

9. Name, address, and telephone number of your attorney, in connection with this illness/injury.

Name: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

10. Have you filed a lawsuit against any party because of this accident? O Yes O No

If yes, provide the name of the defendant, the court, the court number and the name, address, and telephone number of the other party's attorney.

CERTIFICATION AND AGREEMENT: To the best of my knowledge and belief, the information provided above is true and accurate. I understand the Laborers Welfare Plan will rely on the information I have provided in making decisions with regard to benefits. I understand if anything is untruthful, it could result in my termination and/or the termination of my dependents and recoupment by the plan. I agree to inform the Plan if any of the information I have provided changes. I agree to assist the Plan in pursuing any claim to which it may be subrogated and to reimburse the Plan for any amounts to which it may be entitled. Furthermore, I hereby authorize any medical provider, attorney or agent, or any other person or corporation to release any medical information relating to the incident to The Laborers' Benefit Office. I authorize The Laborers' Benefit Office to release information regarding any claims to directly seek and receive such reimbursement from any third-party payments that may in the future, become payable because of this injury.

Processor: _____

Date: _____

Signature of the ill or injured party (over age 18): _____

Signature of Legal Guardian (if under age 18): _____