

MICHIGAN GLASS AND GLAZING INDUSTRY WELFARE INSURANCE FUND

P.O. Box 966
 Troy, Michigan 48099-0966
 248-641-4957

NOTE: YOUR APPLICATION FOR BENEFITS WILL BE DELAYED UNLESS ALL QUESTIONS ARE FULLY COMPLETED.

TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME (PLEASE PRINT) _____

NO. AND STREET _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

TELEPHONE NO. _____

NAME OF LAST EMPLOYER _____

DATE LAST EMPLOYED _____

ARE YOU, YOUR SPOUSE OR CHILD COVERED UNDER ANY OTHER HOSPITAL, SURGICAL, MEDICAL BENEFIT PLAN?

NO YES
 IF YES, PLEASE COMPLETE

Group Plan Individual Policy School Plan

NAME OF OTHER PLAN _____

OTHER POLICY NUMBER _____

IF CLAIM IS FOR DEPENDENT:

NAME OF DEPENDENT _____

DATE OF BIRTH _____

Marital Status: Single Married
 Widowed Separated Divorced

EMPLOYED? NO YES

SPOUSE'S NAME _____

NAME OF SPOUSE'S PRESENT OR MOST RECENT EMPLOYER _____

ADDRESS OF SPOUSE'S EMPLOYER _____

NAME OF SPOUSE'S INSURANCE CARRIER - POLICY NO. _____

I HEREBY APPLY FOR BENEFITS FOR: Self Unmarried Child
 Spouse

IS DEPENDENT A STUDENT?
 NO YES FULL TIME PART TIME

IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? YES NO

COMPLETE ONLY IF CLAIM CAUSED BY INJURY	DATE OF INJURY, HOUR (AM/PM) Where did the accident happen? HOW DID IT HAPPEN? _____
COMPLETE ONLY IF CLAIM CAUSED BY ILLNESS	HAS TREATMENT EVER BEEN RENDERED FOR THIS CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO WHEN WAS THE PHYSICIAN FIRST CONSULTED? _____ DATE _____
COMPLETE IF CLAIM INCLUDES DISABILITY BENEFITS FOR EMPLOYEES	FIRST DATE YOU WERE UNABLE TO WORK? _____ DATE YOU RETURNED TO WORK? _____ IS DISABILITY A RESULT OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH MICHIGAN GLASS AND GLAZING INDUSTRY WELFARE INSURANCE FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED (INCLUDING COPIES OF THEIR RECORDS). I ALSO AUTHORIZE ANY UNION, TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH MICHIGAN GLASS AND GLAZING INDUSTRY WELFARE INSURANCE FUND WITH INFORMATION REGARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED.

DATE _____ EMPLOYEES SIGNATURE _____

PLEASE BE SURE TO ATTACH ITEMIZED BILLS

TO BE COMPLETED BY EMPLOYER FOR EMPLOYEE WEEKLY DISABILITY BENEFITS ONLY-

(1) OCCUPATION _____	DATE LAST WORKED _____	DATE RETURNED TO WORK _____	DID DISABILITY OCCUR DUE TO OCCUPATIONAL CAUSES? <input type="checkbox"/> YES <input type="checkbox"/> NO
(2) HAS EMPLOYMENT TERMINATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHEN _____	FOR WHAT REASON _____	
(3) DOES THE EMPLOYEE HAVE OTHER INSURANCE COVERAGE FOR THIS CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES - EXPLAIN _____		
EMPLOYER _____	SIGNED BY _____		
DATE _____	TITLE _____		



PART A TO BE COMPLETED BY PATIENT (EMPLOYEE)

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
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MICHIGAN GLASS AND GLAZING INDUSTRY WELFARE INSURANCE FUND P.O. Box 966 Troy, Michigan 48099-0966	
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CLAIMANT'S ASSIGNMENT (READ BEFORE SIGNING):
I hereby authorize Michigan Glass and Glazing Welfare Insurance Fund to pay directly to the above named physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Plan to the extent of his interest as established herewith.

(Date)

(Signature of Claimant)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS A MINOR)

DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(If diagnosis code other than ICDA* used, give name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? PREGNANCY? If yes, approximate date pregnancy commenced

YES NO YES NO DATE _____

Date of Services	Place of Services†	Description of Surgical or Medical Services Rendered	Procedure Code-if used (If code other than CPT** used, give name)	Charges
Total Charges				\$ _____
Amount Paid				\$ _____
Balance Due				\$ _____

- IO - Doctor's Office IH - Inpatient Hospital NH - Nursing Home
- H - Patient's Home OH - Outpatient Hospital OL - Other Locations
- *ICDA - International Classification of Diseases
- ** CPT - Current Procedural Terminology (current edition)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED _____

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION _____

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES NO If yes, when and describe _____

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
YES NO

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to work)
FROM _____ THRU _____

9. PATIENT WAS PARTIALLY DISABLED
FROM _____ THRU _____

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK _____

11. PATIENT WAS HOUSE CONFINED
FROM _____ THRU _____

12. DOES PATIENT HAVE OTHER HEALTH COVERAGE?
YES NO If yes, please identify _____

Must be furnished under authority of law.
Individual practitioners - S.S. No. _____
All others - I.D. No. _____

13. I DO NOT ACCEPT ASSIGNMENT

Date	Physician's name (print)	Signature	Degree	Telephone

Street Address	City or Town	State or Province	Zip Code