**RETURN COMPLETED FORM TO:**

**Michigan Regional Council of Carpenters' Employee Benefits Fund**
P.O. BOX 4540 • Troy, MI 48099-4540
(248) 641-4950 • (800) 572-2525 TOLL FREE

## MEMBER COMPLETES AND SIGNS THIS SECTION

Name of Member_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date of Birth_____

Soc. Sec. No._____ Occupation_____ Local No._____

Home Address_____ Telephone No._____
Street City Zip

Your present or last Employer's Name and Address_____

If Claim Is For Member's Disability, Show Date Last Worked_____ Date Resumed Work_____

**COMPLETE IF CLAIM IS FOR DEPENDENT**

Name of Dependent Relationship Date of Birth

Is Dependent Employed? Yes ☐ No ☐ If Yes, State Where:

**Family Employment** - Complete this section only if other members, including dependent minors, are employed

| Name of Family Member (print) First Middle Last | Relationship | Date of Birth | Employer's Phone No.(Include Area Code) |
|---|---|---|---|
| | | | |

| Employer's Name (print) | Employer's Address - Street | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

**FOR ALL CLAIMS**

Nature of sickness or injury_____

Date accident occurred or sickness began_____ Date first treated_____

If hospitallized, Name of Hospital_____ Admitted_____ (date) Discharged_____ (date)

Was surgery performed?_____ If Yes, give nature_____

Is this claim based on an accident? Yes ☐ No ☐

If yes, give date_____ and time_____ a.m._____ p.m.

Where did accident occur?_____

How did accident happen?_____

Did injury occur in the course of any employment? Yes ☐ No ☐
Have you, or do you intend to file this claim under Workmen's Compensation? Yes ☐ No ☐

Are any of the expenses in this claim covered by:
(1) Other insurance coverage, or (2) any Blue Cross or Blue Shield Plan, or, (3) other hospital, surgical, medical benefit or service plan, or (4) union welfare plan, or (5) Medicare? Yes ☐ No ☐
If the answer is "Yes", give the name, address, and policy number (if known) of the other insurance carrier on the line provided below.

_____ Name _____ Address _____ Policy Number

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Michigan Regional Council of Carpenters' Employee Benefits Fund, of any facts concerning the injury, illness, or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original. (If claim is for spouse, spouse must also sign.)

**NOTICE AND ASSIGNMENT**

Claimant understands that benefits are not payable by this Fund for any accidental bodily injury, sickness, or occupational diseases which arises out of or occurs in the course of any occupation or employment for wage or profit.

In the event any Worker's Compensation payment is made to the claiment for part or all of the disability covered by this claim form, at any time, whether by way of decision, redemption, voluntary payment or otherwise, the claiment hereby assigns to the Michigan Regional Council of Carpenters' Employee Benefits Fund that portion of any such payment equal to the benefits paid by the said fund to or on behalf of the claiment.

The Claimant agrees to notify the foregoing named Fund, at least thirty (30) days prior thereto, of the date and location of the trial or redemption of any such Worker's Compensation Claim.

_____ Spouse's Signature

_____ Claimant's Signature

_____ Date

# ATTENDING PHYSICIANS STATEMENT

PATIENT'S NAME AND ADDRESS | DATE OF BIRTH

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 YES ☐ NO ☐ | PREGNANCY YES ☐ NO ☐ | If yes, approximate date pregnancy commenced DATE

3. REPORT OF SERVICES (Or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

| 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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)

TOTAL CHARGES ▶ $_____
AMOUNT PAID ▶ $_____
BALANCE DUE ▶ $_____

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: Through:

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

10. TO YOUR KNOWLEDGE DOES PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE? IF "YES" IDENTIFY.
YES ☐ NO ☐

Date | Physician's Name (Print) | Signature | Degree | Telephone

Street Address | City or Town | State or Province | Zip Code

PHYSICIAN'S TAXPAYER IDENTIFICATION NUMBER _____