—PLEASE NOTE—

YOUR HEALTH CARE PLAN GIVES YOU QUALITY HEALTH CARE COVERAGE. YOU MAY SAVE TIME AND OUT-OF-POCKET EXPENSES BY CHOOSING A COST EFFECTIVE OPTION. TO TAKE ADVANTAGE OF COST SAVINGS TO YOU, PLEASE NOTE THE FOLLOWING:

- **Utilize one of the Preferred Provider Organization (PPO) Hospitals, physicians and dentists along with Postal Prescription Services mail order Prescription drug program.**
- **Request your doctor to obtain Pre-certification Review prior to a hospital admission by calling Blue Cross (800) 274-7767.**
- **Select a Podiatry Plan of California physician for podiatry treatment. For information call (800) 367-7762.**

I. B. E. W. LOCAL #332 HEALTH AND WELFARE PLAN

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BLUE CROSS PRUDENT BUYER PLAN
P. O. BOX 60007
LOS ANGELES, CA 90060-0007

IMPORTANT
PLEASE TAKE TIME TO CHECK OVER THIS FORM TO MAKE SURE YOU HAVE ANSWERED ALL QUESTIONS. YOUR COOPERATION WILL HELP YOUR TRUST FUND TO GIVE YOU PROMPT AND EFFICIENT SERVICE. NOTE ASSIGNMENT PROVISION ON OTHER SIDE.
Board of Trustees

PART 1

1. Eligible Employee _____ (First / Initial / Last) Male ☐ Female ☐ Social Security No. ___/___/___

2. Name of Current Employer: _____

_____ (Street Address)

_____ (City / State / Zip)

3. Name of Patient _____ Birth Date _____

4. If Patient is your dependent, give relationship _____
If Patient is a child, do you claim as Income Tax Deduction? Yes ☐ No ☐
Married? Yes ☐ No ☐ Working? Yes ☐ No ☐ If yes; number of hours per month _____

5. Are you married? Yes ☐ No ☐ If yes, give name of spouse _____
Is spouse employed? Yes ☐ No ☐ Name of employer. _____
Does spouse have group insurance at place of employment? Yes ☐ No ☐ If yes, give name and address of insurance company providing such benefits _____
_____
Policy and/or group number _____ Spouse' Social Security No. ___/___/___

6. To be completed by spouse: I hereby authorize any Union, Trust Fund, Employer or Insurance Company to furnish United Administrative Services with information regarding benefits to which I/we may be entitled.

Date signed _____ Signature _____

7. Was Patient's condition caused by his employment? Yes ☐ No ☐
8. Is person for whom claim is made eligible for Medicare? Yes ☐ No ☐
9. Complete this section if this claim is due to an accident:

_____ (Date of Injury / Time — AM - PM / Where did injury occur?)

Full details of accident: _____
_____
_____

PART 2

I certify that the above information is true and correct.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to UNITED ADMINISTRATIVE SERVICES, the legal representative of the above named Trust, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by UNITED ADMINISTRATIVE SERVICES, legal representative of the above named Trust, to determine eligibility for benefits under an existing policy. Any information obtained will not be released by UNITED ADMINISTRATIVE SERVICES to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE this AUTHORIZATION shall be valid during the pendency of this claim.

THIRD PARTY LIABILITY

I AGREE to reimburse the Fund for any benefits paid by the Fund on this claim in the event of any recovery from any third party responsible for the injury or sickness upon which it is based.

Signed _____ (Employee's Signature)

Address _____ (Number / Street)

Date signed _____ City _____ State _____ Zip _____

PART 3 PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*	5. PATIENT'S SEX MALE ☐ FEMALE ☐	6. INSURED'S I.D. No. or **MEDICARE No.** *(Include any letters)*
	7. Patient's Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐	8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy holder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ NO ☐ B. AN AUTO ACCIDENT YES ☐ NO ☐	11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment below.

Signed_____ Date_____

13. ASSIGNMENT OF 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 due under this Health Plan. I understand that this assignment gives the Plan administrator the authority to make payment to the undersigned physician and that this assignment cannot be revoked after services have been rendered to me without the written consent of the physician.

_____
(INSURED OR AUTHORIZED PERSON)—Original Signature Required

PART 4 PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ◀	ILLNESS (FIRST SYMPTOM) or INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE.

1
2
3
4

24 A DATE OF SERVICE	B place of SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (INDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN		26. TOTAL CHARGE	27. AMT. PAID	28. BAL DUE
SIGNED DATE	29. YOUR SOCIAL SECURITY NO.	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & 30. TELEPHONE NO.		
31. YOUR PATIENT'S ACCOUNT NO.	32. YOUR EMPLOYER I.D. NO.	I.D. NO.		