

MEDICAL CLAIM (Non-Occupational Sickness or Accident)

Send completed form with itemized bills within 90 days to:
Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119

PART I — EMPLOYEE MUST COMPLETE and return within 90 days (Please print)

Employee's Name (Last, First, Middle Initial) <i>Please Print</i>		Birth Date (Month-Day-Year)		Social Security Number		Local Union Number		
Spouse's Name (Last, First, Middle Initial) <i>Please Print</i>		Birth Date (Month-Day-Year)		Social Security Number		Home Phone ()		
Home Address <i>Please Print</i>				City		State	Zip	Employee's Employer
Patient's Name (Last, First, Middle Initial) <i>Please Print</i>	Social Security Number	Birth Date (Month-Day-Year)	If Dependent, Relationship?	Is Disability Due to Work Incurred Condition? YES <input type="checkbox"/> NO <input type="checkbox"/>		If Full-Time Student, Name School		
If Disability is Due to Accident, Describe How, When and Where?								

Is Patient Covered by Any Other Health Insurance, Group Plan or Government Plan?
YES NO If Answer is Yes, Complete Questions Below.

Name and Address of Patient's Other Plan or Group		Group No. or Policy No.	
Name of Employer or Organization Providing Other Coverage		Name of Primary Person Covered Under Other Plan	Identifying No./Social Security No. of Primary Person Covered Under Other Plan

Check if this is your first claim. Check if you have moved since your last claim.

Employee Assignment of Benefits

I hereby authorize the administrator to pay to the below named physician any payments otherwise due and payable to me for medical services rendered to me or one of my eligible dependents by the below named physician.

Date Signed (Month-Day-Year)	Employee's Signature
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IMPORTANT: Only the plan office can verify eligibility. A statement of eligibility furnished by a local union or other source will not be honored if in error.

PART II — AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer, union or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse or my minor children and any other non-medical information of me, my spouse or my minor children to give to the Plan or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by the Plan, its Trustees or its authorized claims paying administrator to determine eligibility for benefits or services under the Plan. Any information obtained will not be released by the Plan to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., group policyholder, or other persons or organizations performing direct administrative, professional, medical or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I UNDERSTAND that I may request to receive a copy of this authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE THIS Authorization shall be valid for the duration of my coverage under this Plan or through the third calendar year from the date shown below, whichever is earlier.

Patient's Signature	Employee's Signature	Date Signed (Month-Day-Year)
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NOTE TO THE DOCTOR OR PROVIDER:

This authorization must be given to the patient or sent to the designated address at the top of this form. If you wish, you may copy the authorization.

PART III (over) TO BE COMPLETED BY ATTENDING PHYSICIAN ONLY. Anesthetist or X-Ray Technician File Statement Only.

