MEDICAL CLAIM (Non-Occupational Sickness or Accident) RETIREES ONLY

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 — RETIREE MUST COMPLETE and return within 90 days (Please Print)

Retiree's Name (Last, First, Middle Initial) *Please Print*	Birth Date (Month-Day-Year)	Social Security Number	Local Union Number
Spouse's Name (Last, First, Middle Initial) *Please Print*	Birth Date (Month-Day-Year)	Social Security Number	Home Phone ( )

Home Address *Please Print*	City	State	Zip	Employer at Retirement

Patient's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)

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.

Retiree 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 my covered spouse by the below named physician.

Date Signed (Month-Day-Year)	Retiree's Signature

IMPORTANT: Only the TBT Plan Administration 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 or my covered spouse and any other non-medical information of me or my covered spouse 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	Retiree's Signature	Date Signed (Month-Day-Year)

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.

PART III — PHYSICIAN MUST COMPLETE (Please type or print)

Name of Patient (Last, First, Middle Initial)				
Physician's Diagnosis (Describe Complications if Any)				
Is Disability Due to Work Incurred Condition? YES ❑ NO ❑	Is Disability Due to Pregnancy? YES ❑ NO ❑	Is Disability Due to Alcoholism or Narcotic Addiction? YES ❑ NO ❑		
Name of Hospital (If Hospitalized)	Admission Date (Month-Day-Year)	Dismissal Date (Month-Day-Year)	Does Patient Have Other Health Plan Coverage? YES ❑ NO ❑	Name of Health Plan

Patient Disabled From _____ (Month-Day-Year) **To** _____ (Month-Day-Year)

Date of Service (Month-Day-Year)	1974 RVS/CPT Code	Description of Services (including examination, treatment, x-ray, etc.)	Fee Charged	Plan Office Use Only

IMPORTANT

If Not Medicare-entitled: For payment, pre-admission required prior to non-emergency hospitalization and within 72 hours of an emergency admission. Call Blue Cross Life and Health at (800) 274-7767 for California residents, or if out-of-state, call Health Care Evaluation (HCE) at (800) 333-3018.

If Medicare-entitled: Medicare is a primary source of benefits. Medical Review is not required.

PHYSICIAN'S STATEMENT

I hereby authorize the Teamsters Benefit Trust or its representatives to examine all medical records pertaining to this patient's disability.

Date Signed (Month-Day-Year)	Physician's Signature

ASSIGNMENT NOT ACCEPTABLE UNLESS PHYSICIAN'S I.R.S. OR SOCIAL SECURITY NUMBER FURNISHED

Physician's Soc. Sec. No. or IRS Taxpayer's ID No.	Physician's Name/Degree *(Please Print)*		Telephone ( )	
Street Address		City	State	Zip