

JEZELI SA JAKIEKOLWIEK
PYTANIA DOTYCZAJĄCE TEJ
FORM PROSZE TELEFONOWO
WAC DO: CLAIM DEPART-
MENT (312) 233-8899

COORDINATION OF BENEFITS QUESTIONNAIRE FOR DEPENDENT CHILDREN AGES 18-25

IMPORTANTE: SI NECES-
TAN MAS INFORMACION
ACERCA DE ESTE IMPRESO,
LLAMEN A LA DEPARTA-
MENTODE RECLAMACIONES
(312) 233-8899

PLEASE PRINT INFORMATION AND RETURN TO:

SEIU Local 1 & Participating Employers Health Trust

CLAIM DEPARTMENT

111 EAST WACKER DR. • 17th FLOOR • CHICAGO, ILLINOIS 60601 • TELEPHONE (312) 233-8899

This form must be completed in **full** for each new claim filed with this office. Upon completion, please attach your bills to it and return to us.

PART I—TO BE COMPLETED BY EMPLOYEE

Employee's Name: _____ Area Code _____ Phone No. _____

Home Address: _____ City _____ State _____ Zip _____

SSN or **Alternate Identification #**: _____ Birth Date: _____ Sex: _____

Employer: _____ Phone No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Information: Child's Name _____

Date of Birth _____

Sex _____

IMPORTANT — THIS SECTION MUST BE COMPLETED — FAILURE TO COMPLETE THIS SECTION WILL ONLY DELAY THE PROCESSING OF THIS CLAIM.

Employee's Spouse Name: _____ Date of Birth _____

Does employee's spouse have insurance through his or her employer? Yes No

Name of employer sponsoring other insurance _____

Name of employee belonging to other group _____

Group Policy No. and/or Subscriber No. _____

Full name and phone number of the other insurance: _____

(If above answered YES please be sure to send copies of the same bills to the other company.)

Is this claim for an injury? Yes No

If yes:

Where did it occur? _____ Date: _____

How did it happen? _____

Was the injury or illness caused by claimant's employment? Yes No

Is claim for

Medical Emergency? Yes No

Date: _____ Time Onset: _____

Symptoms: _____

In Accident or Emergency Situations did you Contact U.H.S. Immediately at 312-423-4200 Yes No

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form.

Employee Signature: _____ Date: _____

CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

All benefits provided under this Plan are automatically assigned to the provider of service unless a paid in full receipt is furnished to the Claim Office when Claim is made.

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-



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II. INFORMATION ABOUT CHILD

1. Full Name of Child:	_____		
2. Social Security Number:	_____		
3. Child's Date of Birth:	_____	_____	_____
	Month	Day	Year
4. Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
5. Child's Address: (If different than yours)	_____		
	Street		
	_____	_____	_____
	City	State	Zip
6. Is child employed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No - If no, please answer question 8.	
7. Did child elect health care coverage through his or her employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, coverage effective date:	_____		
Full name and phone number of the other insurance:	_____		
8. Is child	<input type="checkbox"/> Single	<input type="checkbox"/> Married - If married, please answer question 9.	
9. Is child's spouse employed?	<input type="checkbox"/> Yes - If employed, please answer question 10.	<input type="checkbox"/> No	
10. Did child elect health care coverage through his or her spouse's employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, coverage effective date:	_____		
Full name and phone number of the other insurance:	_____		

III. SIGNATURE

I affirm that if this child is age 18-25 he or she is not enrolled in any health care coverage offered by the child's or child's spouse's employer and that if he or she becomes enrolled in such coverage in the future, I will inform the Fund within 30 days. I further affirm that the information given on this form is true and correct to the best of my knowledge.

Employee's Signature

Date

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-