STATEMENT OF CLAIM FOR GROUP BENEFITS

Minneapolis Retail Meat Cutters & Food Handlers Health & Welfare Fund
3001 Metro Drive, Suite 500, Bloomington, MN 55425-1412
PHONE: 952-851-5797 Toll Free: 1-844-468-5917 General Fax: 952-854-1632 Claims Fax: 952-851-3521

INSTRUCTIONS FOR COMPLETING THIS FORM

1) **The covered employee is required to complete Sections I and II.**
2) **If you want your benefits paid directly to your physician, sign Section III.**
3) **Attach all itemized bills to the completed form and mail to the Fund. This includes drug and vision claims.**

NOTE: To avoid delay in the processing of your claim, please be sure to answer all questions and sign section II.

SECTION I – EMPLOYEE INFORMATION TO BE COMPLETED

Employee's Full Name	Social Security Number	Date of Birth	Sex ☐ M ☐ F

Home Street Address	City	State	Zip	Telephone No.

Employed By:	Occupation	Date Employed	Are you: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

Claim is for: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Ex-spouse	If Spouse, Date of Marriage	Patient's Name	Sex ☐ M ☐ F	Birthdate

Complete only for claims on dependent children, age 19 or older.
Is child fully dependent on you for principal support and a full-time student? ☐Yes ☐No

If Yes, please provide verification from school

Dependent's Social Security No.	Name of Spouse	Spouse's Date of Birth	Social Security Number

Name, Address and Phone Number of Spouse's Employer

IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE, PREPAID HEALTH PLAN, MEDICARE, OR OTHER GOVERNMENTAL PLAN? ☐YES ☐NO

Policyholder's Name	Group insurance company or plan's name

Certificate number	Policy number	Group insurance company or plan's address (street, city, state, zip)

Is illness or injury due, in any way:
1.) To the patient's occupation? ☐ Yes ☐ No If yes, submit claim to Workers' Compensation
2.) To an automobile accident? ☐ Yes ☐ No If yes, complete this information about your auto insurance carrier.

Name & Address_____Policy Number_____

_____

3.) Any other type of accident? ☐ Yes ☐ No
a) Where did the injury or accident happen_____Date & Hour_____

b) What happened? _____

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SECTION II – REQUIRED EMPLOYEE'S SIGNATURE TO PROCESS ANY CLAIMS

I, hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents to furnish and disclose all known facts concerning this illness or injury, A copy or photocopy of this authorization shall be as valid as the original.

Employee's Signature_____ Date_____

SECTION III – AUTHORIZING BENEFITS TO BE PAID DIRECTLY TO YOUR PHYSICIAN

I, hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for their services as described in their statement but not to exceed the usual and customary charge for those services.

Employee's Signature_____ Date_____