UTAH LABORERS' HEALTH AND WELFARE TRUST FUND

P.O. Box 30262 • Salt Lake City, Utah 84130-0262
Phone: (801) 973-1010 • Toll Free (800) 928-1001

STATEMENT OF CLAIM

It is a crime to complete this form with information which you know is false or to omit any facts which you know are important.

INSURED'S STATEMENT

1. Name of Employee	2. Social Security Number	3. Date of Birth	4. Sex ☐ M ☐ F	5. Local Union No.

6. Home Street Address	City	State	Zip

7. Home Phone / Cell Phone Number	8. Employed By	9. Occupation	10. Business Phone Number

11. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Patient Is ☐ Self ☐ Spouse ☐ Child	Custody of Child ☐ Yes ☐ No	IF CLAIM IS FOR YOUR SPOUSE OR CHILD, PLEASE COMPLETE THE APPROPRIATE SECTION BELOW.

Are you insured under any other group, government, employer, or other insurance plan? ☐ Yes ☐ No

If yes, provide the name, address, policy number, and phone number of the insurance company.

SPOUSE STATEMENT

1. Name of Spouse	2. Social Security Number	3. Date of Birth	4. Sex ☐ M ☐ F	Cell Phone Number

5. Address if different than above	City	State	Zip

6. Is Spouse Employed? ☐ Yes ☐ No	If yes, name and address of employer	Employer Phone Number

Are you insured under any other group, government, employer, or other insurance plan? ☐ Yes ☐ No

If yes, provide the name, address, policy number, and phone number of the insurance company.

CHILD / DEPENDENT STATEMENT

1. Name of Child / Dependent	2. Social Security Number	3. Date of Birth	4. Sex ☐ M ☐ F	Phone Number

5. Address if different than above	City	State	Zip

6. Is Child / Dependent Employed? ☐ Yes ☐ No	If yes, name and address of employer	Employer Phone Number

Are you insured under any other group, government, employer, or other insurance plan? ☐ Yes ☐ No

If yes, provide the name, address, policy number, and phone number of the insurance company.

CLAIM INFORMATION

Date Accident or Illness Began	Nature of Illness or Injury	Was the injury or illness caused by patients employment? ☐ Yes ☐ No	Has there been or will there be a claim filed for this injury or illness with the workmen's compensation carrier? ☐ Yes ☐ No

If injured, how and where did the accident happen?

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OR SERVICE PROVIDER.

SIGNED (INSURED PERSON) _____

DATE _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL DOCTORS, PHARMACISTS, HOSPITALS OR OTHER INSTITUTIONS PROVIDING CARE, TREATMENT, CONSULTATION, DRUGS, OR SUPPLIES TO FURNISH FULL INFORMATION REGARDING MEDICAL HISTORY, PHYSICAL OR MENTAL CONDITION, CONSULTATION, OR TREATMENT RENDERED – INCLUDING COPY OF THEIR RECORDS. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

SIGNED (INSURED PERSON) _____

DATE _____

IMPORTANT NOTE: The Fund is entitled to recover money that you, your dependent or a service provider, if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Fund may also contain reimbursement of interest on this money as well as professional fees incurred and other damages.