SOUTHERN ILLINOIS LABORERS' & EMPLOYERS
HEALTH & WELFARE FUND
5100 LABORERS WAY, STE A; MARION IL 62959
www.silehw.org
1-618-998-1300
CLAIMS DEPARTMENT FAX 1-618-993-8295

2013 CLAIM FORM

FOR HEALTH CARE BENEFITS

A. EMPLOYEE INFORMATION

Name:_____ ☐ Male ☐ Female

Social Security Number:_____

Mailing Address:_____

City:_____ State:_____ ZIP:_____

Telephone –Home:_____ Work:_____

Age:_____ Birthdate: _____

Employer: _____

Email Address:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

*Date of Divorce or Legal Separation*_____

B. SPOUSE INFORMATION

Name:_____

Social Security Number:_____

Age_____ Birthdate: _____

*Employer:_____

Employer Address:_____

Employer Telephone:_____

Full Time: _____Part Time: _____

***Complete Section D if Spouse is Covered by Group Insurance at Place of Employment.**

C. FAMILY INFORMATION

	NAME	SOCIAL SECURITY # REQUIRED	AGE 19 TO 26 Employer Name, Address & Telephone #	Other Insurance Available?	BIRTHDATE	SEX
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		

D. IF SPOUSE HAS INSURANCE, PLEASE COMPLETE THE SECTION BELOW.

MEDICAL INSURANCE ☐ YES ☐ NO DRUG CARD ☐ YES ☐ NO	DENTAL INSURANCE ☐ YES ☐ NO
Insurance Company Name:	Insurance Company Name:
Telephone:	Telephone:
Family Members Covered:	Family Members Covered:
Policyholder Name:	Policyholder Name:
Identification Number:	Identification Number:

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish payor of this claim or their duty authorized representative with full information regarding treatment rendered (including copies of their records). I/We also authorize any union, trust fund, employer or insurance carrier to furnish payor of this claim or their duty authorized representative with information regarding benefits to which I/we may be entitled. (If claim for spouse, spouse also must sign.) A copy or photocopy of this authorization shall be considered as effective and valid as the original.

CLAIM FORM MUST BE SIGNED AND DATED

Date	Spouse's Signature	Member Signature
	X	X