

SOUTHERN ILLINOIS LABORERS' & EMPLOYERS  
 HEALTH & WELFARE FUND  
 5100 ED SMITH WAY, STE A; MARION IL 62959  
[www.silehw.org](http://www.silehw.org)  
 1-618-998-1300  
 CLAIMS DEPARTMENT FAX 1-618-993-8295

# 2014 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 <input type="checkbox"/> YES <input type="checkbox"/> NO DRUG CARD <input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> 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 X	Member Signature X
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