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

2025 CLAIM FORM

FOR HEALTH CARE BENEFITS

PAGE 1 of 2-

CLAIM FORM MUST BE SIGNED AND DATED ON PAGE 2 FOR BENEFITS TO BE PAID

A. EMPLOYEE INFORMATION

Name: _____ □ Male □ Female

Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Telephone –Home: _____ Work: _____

Age: _____ Birthdate: _____

Local Union: _____ Employer: _____

Email Address: _____

B. SPOUSE INFORMATION

Name: _____

Social Security Number: _____

Age_____ Birthdate: _____

*Employer: _____

Employer Address: _____

Employer Telephone: _____

Full Time: _____Part Time: _____

Phone Number: _____

Complete Section D if Spouse is Employed or if Other Insurance is available.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated *Date of Divorce or Legal Separation*_____

C. FAMILY INFORMATION

	NAME	SOCIAL SECURITY # REQUIRED	AGE 19 TO 26 Employer Name, Address & Telephone #	Other nsurance? (If Yes, Complete Section D)	BIRTHDATE	SEX
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		

**PLEASE USE REVERSE SIDE FOR ADDITIONAL DEPENDENTS

D. PLEASE COMPLETE THE SECTION BELOW FOR SPOUSE OR IF OTHER INSURANCE IS AVAILABLE

DO YOU CARRY A SEPARATE AIR AMBULANCE (AIR EVAC) POLICY? ☐ YES ☐ NO IF YES, LIST PROVIDER: _____

PLEASE SEE REVERSE SIDE. THE FRONT AND BACK OF THIS FORM MUST BE COMPLETED.

MEDICAL INSURANCE ☐ **YES** ☐ **NO** **PRESCRIPTION DRUG CARD** ☐ **YES** ☐ **NO**	**DENTAL INSURANCE** ☐ **YES** ☐ **NO**
Insurance Company Name:	Insurance Company Name:
Telephone: Date Coverage Began:	Telephone: Date Coverage Began:
Family Members Covered:	Family Members Covered:
Policyholder Name:	Policyholder Name:
Relationship:	Relationship:
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**

	NAME	**SOCIAL SECURITY # REQUIRED**	**AGE 19 TO 26 Employer Name, Address & Telephone #**	**Other insurance? (If Yes, Complete Section D)**	**BIRTHDATE**	**SEX**
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		