

# Operating Engineers Local #49 Health & Welfare Fund

## INITIAL REPORT OF CLAIMS

GROUP: **5WM00490**

**NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY**

### INSTRUCTIONS:

This form is to be completed by the member. Complete member's section fully. Be sure to include your Social Security Number and sign member's signature section. Remember to attach itemized bills.

### RETURN COMPLETED FORM TO:

Operating Engineers Local #49 Health & Welfare Fund  
3001 Metro Drive - Suite 500  
Bloomington, MN 55425  
952-854-0795 | Fax 952-851-3521 | Toll Free 800-535-6373

### MEMBER COMPLETES THIS SECTION:

Name of Member		Home Phone	
Date of Birth	Social Security Number	Occupation	
Employer			
Home Address	City	State	Zip Code
If claims is for member's disability, show date last worked:		Date resumed work:	

### COMPLETE THIS SECTION IF CLAIM IS FOR DEPENDENT:

Name of Dependent	Relationship to Member	Date of Birth	
Is Dependent Employed? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, state name of Employer			
Is the Patient Covered by Any Other Insurance, Prepaid Health Plan, Medicare or Other Governmental Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO		Insured's Name	
Group Insurance Company or Plan's Name		Policy Number	
Group Insurance Company or Plan's Address	City	State	Zip Code
Name of Spouse	Spouse's Date of Birth	Spouse's Social Security Number	

### COMPLETE THIS SECTION FOR ALL CLAIMS:

Nature of Sickness or Injury:	Date Accident Occurred or Sickness Began:	Date First Treated:
If Hospitalized, Name of Hospital:	Date Admitted:	Date Discharged:
Did someone intentionally cause this injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Was injury due to an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Did the accident happen on your property? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, address where accident occurred:		
Was this due to an auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	Did injury or illness occur in the course of employment? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you filed this claim under Workmen's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you started a lawsuit related in any way to this injury/illness? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you received any settlement, payment, recovery of benefits, including insurance company policy, related in any way to this injury/illness? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you an owner or officer of your employer? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you receiving accident/sick pay from your employer? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you hired an attorney to represent you regarding this claim? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physician to release information concerning my enrollment, related records and medical records to the Operating Engineers Local #49 Health & Welfare Fund.**

Insured Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

**INSTRUCTIONS:**

**ATTENDING PHYSICIAN'S STATEMENT**

This form does not have to be completed, if you can furnish the Administrator with a complete itemized and coded statement of services from the doctor. If you do not have a complete itemized and coded statement, your physician may use this form to report his/her services and charges.

**DISABILITY**

To collect disability benefits, your physician must complete questions, 1, 2, 4, 5, 7, 8, 9 and sign and date this form. If you are unable to work due to a work related disability that occurred while you were working in the jurisdiction of Local Union #49, you may submit evidence (such as check stubs) that you are receiving weekly disability benefits from Worker's Compensation. You will be credited with 25 disability hours for each full week of disability. You do not need to complete this form.

**ATTENDING PHYSICIAN'S STATEMENT:**

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name).

2. Is the condition due to injury or sickness arising out of patient's employment?  YES  NO  
Is condition due to pregnancy? If yes, approximate date pregnancy commenced.  
 YES  NO

3. Report of services (or attach itemized bill. If previous form submitted to this carrier, you need show only dates and services since last report).

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure code - If used If code other than CPT used, give name	Charges	Office Use Only
+O = Doctor's Office    IH = Inpatient Hospital H = Patient's Home    OH = Outpatient Hospital NH = Nursing Home    OL = Other Location ICDA = International Classification of Diseases CPT = Current Procedure Terminology (current location)				Total Charges	\$ _____
				Amount Paid	\$ _____
				Balance Due	\$ _____

4. Date symptoms first appeared or accident happened.    5. Date patient first consulted you for this condition.    6. Has patient ever had same or similar condition? if yes, when and describe.  YES  NO

7. Is patient still under your care for this condition?  YES  NO    8. Patient was continuously totally disabled (unable to work). From:    Thru:    9. Date patient should be able to return to work, if still disabled.

10. Does patient have other health coverage? If yes, please identify  YES  NO    Taxpayers identification number: \_\_\_\_\_

Print Physician's Name	Physician's Signature	Degree	Date
Street address		Telephone	
City	Providence	State	Zip Code

**MEMBERS ASSIGNMENT (PLEASE READ BEFORE SIGNING)**

To be completed and signed by the Member if direct payment by fund to surgeon or physician is desired. (This assignment may not be honored if signed by a dependent or person other than the Insured Member).

I hereby authorize the Operating Engineers Local #49 Health & Welfare Fund to pay directly to the above named hospital or physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy.

Insured Member's Signature \_\_\_\_\_ Date \_\_\_\_\_