HEALTH INSURANCE CLAIM FORM
TELE # (602) 650-8161

MAIL COMPLETED FORM TO:
PO BOX 16200
PHOENIX, ARIZONA 85011-1600

INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL #428 HEALTH & WELFARE TRUST FUND

THE PARTICIPANT MUST ANSWER ALL QUESTIONS THAT APPLY AND SIGN

THIS FORM IS COMPLETED BY THE PARTICIPANT ONCE EVERY 12 MONTHS AND BY THE DEPENDENTS EVERY SIX MONTHS TO INFORM THE TRUST FUNDS OF CHANGES IN FAMILY STATUS OR THE ADDITION OF OTHER MEDICAL INSURANCE COVERAGE.

THIS INFORMATION REQUESTED WILL FACILITATE THE PAYMENT OF YOUR CLAIMS. IF OTHER INSURANCE IS INVOLVED, INFORMING THE TRUST FUND MAY SAVE YOU CERTAIN OUT-OF-POCKET EXPENSE THROUGH THE COORDINATION OF BENEFITS.

OPERATING ENGINEERS LOCAL 428 HEALTH & WELFARE TRUST FUND

1. EMPLOYEE'S NAME		MALE ☐ FEMALE ☐	DATE OF BIRTH	SOCIAL SECURITY NUMBER
2. YOUR ADDRESS (NO. & STREET)	(CITY)	(STATE)	(ZIP CODE)	(TEL #)
3. NAME OF EMPLOYER				ACTIVE EMPLOYED ☐ ☐
4. SPOUSE'S NAME		SPOUSE'S SOCIAL SECURITY #		SPOUSE'S DATE OF BIRTH
IF SPOUSE IS EMPLOYED PLEASE ANSWER QUESTION #5				
5. NAME AND ADDRESS OF SPOUSE'S EMPLOYER				PART TIME ☐ FULL TIME ☐
IS YOUR SPOUSE COVERED BY GROUP MEDICAL INSURANCE THROUGH HER EMPLOYMENT?				YES ☐ NO ☐
IF YES, PLEASE ANSWER A., B., C., D. & E.				
A. NAME OF INSURANCE COMPANY			B. POLICY NUMBER	
C. ADDRESS (NO. & STREET)		(CITY)	(STATE)	(ZIP CODE)
D. FAMILY COVERAGE ☐	SINGLE COVERAGE ☐		PLAN EFFECTIVE DATE	
E. TYPE OF COVERAGE	MEDICAL ☐	DENTAL ☐	VISION ☐	
DO YOU HAVE DEPENDENT(S) EMPLOYED BY AN EMPLOYER WHO OFFERS GROUP MEDICAL INSURANCE?				YES ☐ NO ☐
6. DEPENDENT NAME		IF YES, PLEASE ANSWER 6, F., G., H., I. & J.		
F. NAME AND ADDRESS OF DEPENDENT'S EMPLOYER				PART TIME ☐ FULL TIME ☐
G. NAME OF INSURANCE COMPANY			H. POLICY NUMBER	
I. ADDRESS (NO. & STREET)		(CITY)	(STATE)	(ZIP CODE)
J. TYPE OF COVERAGE	MEDICAL ☐	DENTAL ☐	VISION ☐	PLAN EFFECTIVE DATE

AUTHORIZATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator to provide American Benefit Plan Administrators or an agent, attorney, consumer reporting agency or independent administrator, acting on American Benefit Plan Administrators behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness or use of drugs or alcohol. I also authorize the employer or benefit plan administrator to provide American Benefit Plan Administrators with financial or employment related information. I understand this information will be used by American Benefit Plan Administrators for the purpose of evaluating my claim for benefits, and I or any authorized representative will receive a copy of this signed form upon request.

I further authorize American Benefit Plan Administrators to release the benefit plan administrator, a summary of claims incurred by me and my covered dependents for the purpose of verifying claims submitted under my plan of benefits. This authorization is valid from the date signed for the duration of the claim.

NAME OF PATIENT/PARTICIPANT (OR DECEASED)

SIGNATURE OF CUSTODIAL PARENT IF MEDICAL SUPPORT ORDER IS INVOLVED

SIGNATURE OF PATIENT/PARTICIPANT, AUTHORIZED REPRESENTATIVE OR NEXT OF KIN

DATE SIGNED (MONTH/DATE/YEAR)

IF PATIENT/EMPLOYEE IS UNDER 18 YEARS OR INCAPACITATED, PARENT OR GUARDIAN MUST SIGN. IF PATIENT/EMPLOYEE IS DISEASED, AUTHORIZED REPRESENTATIVE OR NEXT OF KIN MUST SIGN.

NOTICE TO ALL PARTIES

IT IS FRAUD TO KNOWINGLY FILL OUT THIS FORM WITH FALSE INFORMATION OR TO KNOWINGLY OMIT IMPORTANT FACTS CRIMINAL AND /OR CIVIL PENALTIES CAN RESULT FROM SUCH ACTS.