NEW CLAIM FORM. ONE PER FAMILY

U.A. PLUMBERS
LOCAL UNION #68

CLAIM FORM *GROUP INSURANCE*
MUST BE FILLED OUT EVERY YEAR FOR EACH ELIGIBLE MEMBER IN HOUSEHOLD

Mail completed form to:
U. A. Plumbers Local Union #68
Group Protection Plan
P.O. Box 8726
Houston, Texas 77249
(713) 869.2592 Fax # 713-862-4877
Email: benefits@plu68.com

TO BE COMPLETED BY EMPLOYEE ♦ ANSWER ALL QUESTIONS THAT APPLY ♦ SIGN WHERE INDICATED BY (⊠)

EMPLOYEE NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH	LAST 4 SOCIAL SECURITY NO.
COMPLETE HOME ADDRESS	CITY	ZIP	TELEPHONE NO.
EMAIL ADDRESS	CELL NUMBER		☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED

DEPENDENT SECTION Age 19 to 26 Complete annual Dependent Enrollment Form or provide College enrollment of at least 12 credit hours per semester

NAME OF **DEPENDENT**	☐ MALE ☐ FEMALE	DATE OF BIRTH
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SPOUSE SECTION *(MUST BE COMPLETED IN ALL CASES)*

Name:		Last 4 Social Security No	DATE OF BIRTH

Has your spouse been employed in the past twelve months: ☐ Yes ☐ No

Employer:		Address:

DO YOU, YOUR SPOUSE, OR DEPENDENT(S) HAVE ANY OTHER INSURANCE, INCLUDING MEDICAID, OTHER THAN THE UA PLUMBERS LOCAL UNION #68 GROUP PROTECTION PLAN?

A.	Group Insurance, or any other arrangement of coverage for individuals in a group?	☐ Yes ☐ No	**B.**	Any coverage for dependents?	☐ Yes ☐ No

GIVE NAME, ADDRESS AND PHONE NUMBER OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS/SERVICES FOR ___SELF___SPOUSE___CHILD

INSURED:	NAME & ADDRESS OF INSURANCE / ORGANIZATION	PHONE NUMBER	POLICY NO. OR IDENTIFICATION NO.

INJURY SECTION:

DATE OF ACCIDENT:		Time	☐ AM ☐ PM	DETAILS OF ACCIDENT		
WAS CLAIMANT AT WORK WHEN THE ACCIDENT OCCURRED?	☐ Yes ☐ No					
WAS DISABILITY CAUSED BY WORK RELATED ACCIDENT?	☐ Yes ☐ No	HAVE YOU FILED A CLAIM WITH WORKERS' COMPENSATION FOR THIS DISABILITY?	☐ Yes ☐ No	FIRST DATE UNABLE TO WORK	DATE RETURNED TO WORK	

I / WE jointly certify that the above information is true and correct. I / WE hereby authorize all doctors, dentists, psychologists, pharmacists, hospital or other institutions providing care, treatment, consultation, drugs, or supplies to furnish U.A. Plumbers LU #68 Group Protection Plan with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered – including a copy of their records. I / WE authorize any insurance carrier, service plan, union, trust fund, or employer to furnish U.A. Plumbers LU #68 Group Protection Plan to release any information relevant to a determination of the applicability of an implementation of a coordination of benefits provision to any insurance carrier, service, plan, union, trust fund or employer requesting such information.

Date	Employee's Signature ⊠	Spouse's Signature ⊠

LU68-GROUP MEDICAL 05/04

By signing this I accept Plan coverage for Dental and Vision benefits, in addition to Medical benefits described in the Plan. I understand, that if for any reason I desire to not accept Dental and Vision benefits, I may contact the Fund Office to record my choice to not accept the Dental and Vision benefits of the Plan.