MID CENTRAL OPERATING ENGINEERS HEALTH & WELFARE FUND

P.O. BOX 9605 • TERRE HAUTE, INDIANA 47808
TOLL FREE: 1-877-299-3699
1-812-232-4384

Name of Member ______________________________ Date of Birth ______________

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Legally Separated ☐ Widow ☐

Last four of SS# ______________ or MOJ MCO# ______________ Telephone No. (______) ______________

Home Address ____

Spouse's Name ______________________________ Date of Birth ______________

IF THIS CLAIM IS FOR YOUR SPOUSE OR DEPENDENT

Name of Dependent (First) ______________ (Last) ______________ Date of Birth ______________

Relationship to Member Spouse ☐ Son ☐ Daughter ☐ Other ☐ Explain other: ______________

Is Dependent Employed? Yes ☐ No ☐ Full Time ☐ Part Time ☐

If Yes, Provide Employer Name ______________________________

Address ____

City/State/Zip ______________________________ Telephone No. (______) ______________

DO YOU OR YOUR DEPENDENT HAVE ANY OTHER GROUP HEALTH INSURANCE

Yes ☐ No ☐ If Yes, complete the following: Who is the policy holder?: ______________

Who is covered under this policy? (list all covered individuals) ______________

Type of coverage: Medical coverage ☐ Medicare ☐ Prescription Coverage ☐ Medicaid ☐

Insurance Company Name: ______________________________

Address: ______________________________ City/State/Zip ______________

Policy No. ______________ Group No. ______________ Telephone No. (______) ______________

ABOUT THIS CLAIM

* Reason for visit: ______________________________
* Was the condition the result of an accident or injury? Yes ☐ No ☐ If, Yes Must provide details
* Tell us how, when and where (address) it happened ______________________________

____

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* Date accident occurred or illness began ______________ Date first treated ______________
* Employment Related Yes ☐ No ☐
* If Yes, Please explain: ______________________________
* Was Work Comp filed Yes ☐ No ☐

MEMBER'S SIGNATURE

I, HEREBY CERTIFY THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE THE RELEASE WHEN REQUESTED BY THE HEALTH AND WELFARE FUND, OR ANY FACTS CONCERNING THE INJURY, ILLNESS, OR TREATMENT AND/OR EMPLOYMENT OF MYSELF OR MY DEPENDENTS. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

X Member's Signature ______________________________ Date ______________