

STATEMENT OF CLAIM FOR GROUP BENEFITS
 Minneapolis Retail Meat Cutters & Food Handlers Health & Welfare Fund
 3001 Metro Drive, Suite 500, Bloomington, MN 55425-1412

PHONE: 952-851-5797 Toll Free: 1-844-468-5917 General Fax: 952-854-1632 Claims Fax: 952-851-3521 Email: mrmc@wilson-mcshane.com

INSTRUCTIONS FOR COMPLETING THIS FORM

- 1) The covered employee is required to complete Sections I and II.
- 2) If you want your benefits paid directly to your physician, sign Section III.
- 3) Attach all itemized bills to the completed form and mail or email to the Fund. This includes drug and vision claims.

NOTE: To avoid delay in the processing of your claim, please be sure to answer all questions and sign section II.

SECTION I – EMPLOYEE INFORMATION TO BE COMPLETED

Employee's Full Name		Social Security Number		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Street Address			City	State	Zip
Telephone No.					
Employed By:	Occupation	Date Employed	Are you: <input type="checkbox"/> Seperated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		
Claim is for: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Ex-spouse	If Spouse, Date of Marriage	Patient's Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	
Complete only for claims on dependant children, age 19 or older. Is child fully dependent on you for principal support and a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, please provide verification from school	
Dependent's Social Security No.	Name of Spouse	Spouse's Date of Birth	Social Security Number		
Name, Address and Phone Number of Spouse's Employer					

IS THE PATIENT COVERED BY ANY OTHER GROUP INSURANCE, PREPAID HEALTH PLAN, MEDICARE, OR OTHER GOVERNMENTAL PLAN? YES NO

Policyholder's Name		Group insurance company or plan's name	
Certificate number	Policy number	Group insurance company or plan's address (street, city, state, zip)	

Is illness or injury due, in any way:

1.) To the patient's occupation? Yes No If yes, submit claim to Workers' Compensation

2.) To an automobile accident? Yes No If yes, complete this information about your auto insurance carrier.

Name & Address _____ Policy Number _____

3.) Any other type of accident? Yes No

a) Where did the injury or accident happen _____ Date & Hour _____

b) What happened? _____

SECTION II – REQUIRED EMPLOYEE'S SIGNATURE TO PROCESS ANY CLAIMS

I, hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents to furnish and disclose all known facts concerning this illness or injury, A copy or photocopy of this authorization shall be as valid as the original.

Employee's Signature _____ Date _____

SECTION III – AUTHORIZING BENEFITS TO BE PAID DIRECTLY TO YOUR PHYSICIAN

I, hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for their services as described in their statement but not to exceed the usual and customary charge for those services.

Employee's Signature _____ Date _____