UNITED FOOD AND COMMERCIAL WORKERS UNION
AND PARTICIPATING FOOD INDUSTRY EMPLOYERS
TRI-STATE HEALTH AND WELFARE FUND

27 Roland Avenue, Suite 100, Mt. Laurel, NJ 08054-1056
800-228-7484 856-793-2500 Fax- 1-856-793-3102

SELF INSURED SUPPLEMENTAL REIMBURSEMENT HOSPITAL-MEDICAL-SURGICAL, AND MAJOR MEDICAL CLAIM FORM

I N S T R U C T I O N S

(1) Please answer all questions 1 through 19 below.
(2) If you wish to assign your benefits to be paid directly to the provider of service, please sign the Authorization to Pay Insurance Benefits below.
(3) If you are covered by any other plan, please submit all bills to the other plan FIRST, then submit itemized bill(s) with a copy of the other plan's Explanation of Benefit Statement(s)
(4) ALL claims should be sent to: UFCW TRI-STATE HEALTH AND WELFARE FUND
27 Roland Avenue, Suite 100,
Mt. Laurel, NJ 08054-1056

1. Employee's Name _____
   Social Security No. _____
   Address _____
   City _____ State _____ Zip _____
   Employer _____ Group# _____
2. Is this an Accident G Sickness? G
   If Accident, describe HOW, WHEN, WHERE (if necessary, attach a letter giving details)
   _____
   _____
   _____
3. Date of Accident or Onset of Sickness _____
4. Is Accident/Sickness due to employment?
   Yes G No G
5. Do you work for another Employer? Yes G No G
6. Name of other Employer
   _____
7. Address of other Employer
   _____
   _____
8. Does your other Employer provide Group Hospital, Surgical and/or Major Medical Insurance?
   Yes G No G
9. Do you attend school full-time? Yes G No G
10. Name & Address of School _____
    _____

If you are married, divorced, or separated answer 11a - 14a

11a. Name of your Spouse
_____
12a. Is he or she employed? Yes G No G
13a. Name of your Spouse's Employer
_____
14a. Address of your Spouse's Employer
_____
_____

If you are single, answer 11b – 14b

11b. Name of your Parent(s)
_____ _____
12b. Is either parent employed? Yes G No G
13b. Name of your Parent(s) employer
_____
14b. Address of your Parent(s) employer
_____
_____

15. Does the Employer named above in 13a or 13b provide Group Hospital and Surgical Insurance for you or your children as a Dependent?
    Yes G No G
16. Name of dependent for whom claim is made
    _____
17. Relationship _____ Birth Date _____
18. Is this dependent employed? Yes G No G
19. If yes, please indicate name/address of employer
    _____
    _____

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment directly to the Provider of Service the benefits specified and otherwise payable to me but not to exceed the balance due of the Provider's regular charges for this period of treatment. I understand I am financially responsible to the Provider for charges not covered by this Agreement.

Date _____ , 20_____ Signed _____