RETURN COMPLETED FORM TO CLAIMS OFFICE,
NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

P.O. BOX 4002
EAU CLAIRE, WISCONSIN 54702

1-800-424-3405 Nationwide
1-715-835-3174 Phone

STATEMENT OF INJURY / ILLNESS

Member's full name ______________________ ID Number ______________ Date of birth __________

Member's marital status ___Single ___Married ___Widowed ___Divorced ___Legally separated Sex ___M ___F

Home address ______________________ (NUMBER AND STREET, CITY, STATE, ZIP CODE) Telephone number ___(   )___________ (AREA CODE)

Name of Patient ______________ Relationship to member ____________ Date of Birth __________ Sex ___M ___F

Patient's marital status ___Single ___Married ___Widowed ___Divorced ___Legally separated

IMPORTANT — PLEASE COMPLETE ALL QUESTIONS.

Date of Injury/ Illness ______________________ Time of Injury (if applicable) __________ AM PM (circle one)

Where did injury occur? ______________________ (CITY, STATE, WHOSE PROPERTY)

____

Describe injury / Illness: Tell how it happened ______________________

____

Did the injury / illness occur as a result of a job for which you were paid? ☐ Yes ☐ No

Is there a possibility that a third party may be responsible for payment of a portion or all of the medical expense? ___Yes ___No

If yes, indicate the name and address of the third party. ______________________

____

If known, also identify the third party's insurance carrier and agent. ______________________

____

Was the injury or sickness caused by any employment? ___Yes ___No

Has there been, or will there be, a claim filed for this disability with the worker's compensation carrier? ___Yes ___No

Other Coverage

Do you, your spouse or dependents have any other group coverage? ___Yes ___No

If "Yes," please complete the following: Person's Birthdate

a. Name of person insured in other group ______________________ __________

b. Name and address of other group plan or insurance company ______________________

____

c. Group and Policy Number ______________________

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 and data concerning disability **to the North Central States Regional Council of Carpenters' Health Fund as well as to any cost containment organizations and entities** retained by or authorized by the Trustees.

Date:__________ Member's Signature ______________________