LAUNDRY & DRY CLEANING WORKERS
INTERNATIONAL UNION LOCAL NO. 52
HEALTH AND WELFARE TRUST
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
Phone: (562) 463-5060

CLAIM FORM

Please answer all applicable questions. Return this completed form with itemized bills for each claim to the above address. Failure to complete this form in full may delay payment of your claim.

EMPLOYEE DATA

Name (First, Middle & Last)	Sex	Date of Birth	Social Security #
	F ☐ M ☐		

Home Address	City	State	Zip	Home Phone

Employed By	Married ☐ Widowed ☐ Single ☐ Divorced ☐

PATIENT DATA

Name (First, Middle & Last)	Sex	Date of Birth	Social Security #
	F ☐ M ☐		

Reason for Claim	If accident, please provide following details:		
Illness ☐ Accident ☐	Date	Place	Describe Accident in Details
Was Illness or accident Work related? Yes ☐ No☐			

SPOUSE DATA (must be completed if claim is for spouse or child)

Name (First, Middle & Last)	Sex	Date of Birth	Social Security #
	F ☐ M ☐		

Home Address (if different from address shown above)

Employer Name	Employer Address	Employer Phone #

OTHER INSURANCE DATA

Was the Patient covered by any other Group Insurance, Medicare or other governmental plan at the time these charges were incurred?

Yes ☐ No ☐

Give the name and address of any other insurance company or organization providing benefits to you, your spouse or dependent children.

Insured Name	Name and Address of Insurance Company or Organization providing benefits	Policy #

AUTHORIZATION TO RELEASE INFORMATION - CERTIFICATION OF ACCURACY

I/We jointly certify that the above information is true and correct. I/We hereby authorize all providers of medical care to furnish the Laundry & Dry Cleaning Workers Local No. 52 Health and Welfare Trust Fund with full information regarding this claim including copies of their records. I/We further authorize the release of this information to any third party, if the release of the information is necessary to the review or payment of the claim; i.e. for a medical necessity review, coordination of benefits determination, etc.

_____ _____ _____ _____

Employee Signature **Date** **Spouse (Patient) Signature** **Date**

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payments directly to the provider of service for all benefits, if any, otherwise payable to me for services on the attached claim but not to exceed the reasonable and customary charge for those services.

_____ _____

Signed (Insured Person) **Date**