T 317.923.4577 | **F** 317.923.7633 | **E** info@ewbtf.org

1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

STATEMENT OF CLAIM

Participant Name:	**SSN:**		
Address:			
City:	**State:**	**Zip:**	
Name of Employer:	**Phone Number:**		
Patient's Name:	**Self**	**Spouse**	**Child**
CLAIM FORM WILL BE RETURNED TO YOU IF NOT COMPLETED IN DETAIL			
List all body parts involved:			
Describe in detail what caused injuries or reason for your visit			
Was this claim a result of an injury?	**Yes**	**No**	
If yes, date of injury			
If yes, location of injury:			
Is any other party liable to pay expenses? If yes, please contact the EWBTF	**Yes**	**No**	
If the claim is for a participant, are/were you disabled?	**Yes**	**No**	
If yes, date last worked:			
If yes, date returned to work:			

If the illness or injury occurred in connection with the patient's employment (Including full-time, part-time or self-employment), a copy of the Workers Compensation carrier's payment or denial is REQURIED. Please contact the EWBTF IMMEDIATELY if the denial is overturned.

I/We certify that the above statements are true and complete. I/We hereby authorize any physician, hospital, employer, union, insurance company, or prepayment organization to furnish to the Electrical Workers Benefit Trust Fund any additional information required in connection with this claim. A photocopy of this authorization shall be as valid as the original. I realize I am liable to contact the EWBTF if there are any changes in the information listed above.

Signature:	**Date:**

THIS GROUP INSURANCE PLAN CONTAINS A NON-DUPLICATION PROVISION WHICH REQUIRES THE COORDINATION OF THE BENEFITS OF THIS POLICY WITH ANY OTHER GROUP INSURANCE BENEFITS WHICH MAY BE PAYABLE NO CLAIM WILL BE CONSIDERED FOR PAYMENT UNTIL PRIMARY RESPONSIBILITY HAS BEEN DETERMINED.CLAIMS MUST BE RECEIVED BY THE ELECTRICAL WORKERS BENEFIT TRUST FUND ADMINISTRATIVE OFFICE WITHIN SIX (6) MONTHS FROM THE DATE OF SERVICE TO BE ELIGIVLE TO BE CONSIDERED