**GENERAL TEAMSTERS AND EMPLOYERS TRUST FUND**

# 1200 WILSHIRE BLVD 5TH FL LOS ANGELES, CA 90017

Telephone (562) 463- 5033 (866) 481 -

# 5841 FAX (562) 463 - 5894

CLAIM FORM MUST BE SUBMITTED WITHIN 90 DAYS OF SERVICE

## ANSWER ALL QUESTIONS THAT APPLY • SIGN WHERE INDICATED

Complete Home Address

 Married Widowed

 Single Divorced

City State Zip Telephone Number

Employed By

 Child

**GIVE THE FOLLOWING INFORMATION ABOUT YOUR SPOUSE. {MUST BE COMPLETED IN ALL CASES)**

Spouse Name Social Security No. Date of Birth

Employer Name Employer Address



**Do you, your spouse, or child have any other Group Insurance (other than the Trust Fund)? If yes, give name and address of insurance company or organization providing benefits for**

 **Yes**  **No**

 **Self**  **Spouse**  **Child**

|  |  |  |
| --- | --- | --- |
| Insured Name | Name and address of insurance company or organization providing benefits or service | Policy No. or Identification No. |
|  |  |  |
|  |  |  |



## WAS INJURY CAUSED BY AN ACCIDENT? YES NO IF "YES", THIS PORTION MUST BE COMPLETED

Date of Accident Was claimant at work Yes

When accident happened No Place and Details of Accident

Date Last Worked Date Returned to Work

Were you places on disability due to this condition? Yes No

I/We jointly certify that the above information is true and correct. I/We hereby authorize all providers of medical care to furnish the General Teamsters and Employers Trust Fund with full information regarding this 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.

Date

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 Signature) Date