

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

P.O. BOX 4002
EAU CLAIRE, WISCONSIN 54702

1-715-835-3174 Local 1-800-472-7368 Wisconsin Toll Free 1-800-331-9565 Out-of-State Toll Free

STATEMENT OF INJURY / ILLNESS

Member's full name _____ Soc. Sec. Number _____ Date of birth _____

Member's marital status ___ Single ___ Married ___ Widowed ___ Divorced ___ Legally separated Sex ___ M ___ F

Home address _____ Telephone number _____
NUMBER AND STREET CITY STATE ZIP CODE (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 _____ AM
(if applicable) _____ 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 _____