

**STONE AND MARBLE MASONS
HEALTH & WELFARE FUND, LOCAL 2, D.C., B.A.C.
7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046**

PHONE
(410) 872-9500

ATTENDING PHYSICIAN MUST
COMPLETE REVERSE

This Side To Be Completed By Employee (Please Print Clearly)

| | | | | | |
|---|---------------------------------|------------|-------------|-----------------------------------|---|
| Name and Home Address of Employee (Print) | | | | Marital Status: | |
| Mr. | Member of Local Union No. _____ | | | <input type="checkbox"/> Single | <input type="checkbox"/> Married <input type="checkbox"/> Widowed |
| Mrs. | Soc. Sec. No. _____ | | | <input type="checkbox"/> Divorced | <input type="checkbox"/> Legally Separated |
| Miss _____ | Date of Birth _____ | | | | |
| No. _____ | Street _____ | City _____ | State _____ | Zip _____ | Month _____ Date _____ Year _____ |

Dependent's Information: (Complete Only If Claim Is For Dependent)

| Name of Dependent | Date of Birth | Relationship | Marital status if other than spouse |
|-------------------|---------------|---|---|
| _____ | _____ | <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed |
| | | <input type="checkbox"/> Other..... (Relationship) | <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated |

List All Employers During Past Three Months: Start with Present

| Employer Name, City and State | Local No. | From | | To | |
|-------------------------------|-----------|-------|-------|-------|-------|
| | | Yr. | Mo. | Yr. | Mo. |
| 1. _____ | _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ | _____ |

Nature of Illness or Disability

| | |
|--|--|
| Date you last worked Due to illness: _____ | Cause of Disability: _____ _____ _____ |
| Month Day Year | |

If disability is due to an accident, state when, where and how it happened _____

Was illness or injury due, in any way, to your occupation?
 Yes No if "YES" Explain _____

| | | |
|------------------------------------|---|--------------------------|
| Date returned to work _____ | If you have filed for "Workmen's Compensation", complete the following Claim No. _____ Ins. Company Name and Address _____ | Date Filed: _____ |
| Month Day Year | | Month Day Year |

Other Group Health Coverage

Is the person for whom claim is being made covered under any other group plan providing health benefits and/or Medicare? YES NO

If YES, complete the following

(a) Person in whose name this other plan is carried _____

(b) Name of Employer _____

(c) Address of Employer _____

(d) Name of insurance company or organization providing benefits _____

(e) Address _____ Policy Number _____

Authorization and Certification

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release any and all information with respect to this claim which may be necessary to determine any amount payable. I certify that the above statements and information are correct.

Signed at _____ on _____
City and State Mo. Day Yr. Signature of Employee

If you wish payment to go directly to the Doctor, carefully read and complete the following. Otherwise, furnish PAID RECEIPTS.

Assignment:
I hereby authorize payment directly to the physician of any benefits otherwise payable to me for services as described on reverse, but such payment shall not exceed the maximum allowable for such services I fully understand that I am financially responsible for all charges not covered by this Plan.

_____ Signature of Employee
Mo. Day Yr.

