

# ARIZONA SHEET METAL TRUST FUNDS

ADMINISTRATOR: Southwest Service Administrators, Inc.  
 2400 W. Dunlap Ave., Suite 250 \* Phoenix, AZ 85021 \* Phone 602-249-3582 \* Toll Free 1-800-474-3485 \* Fax 602-249-3795  
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## BILLING STATEMENT

Use this form to apply for Plan Benefits. (NOTE: Was your condition caused by an on-the-job injury or illness? If so - do not complete this form; instead, contact your employer who will assist you in filing your Workmen's Compensation claim.)  
**INSTRUCTIONS - READ THE "HOW TO OBTAIN BENEFITS" SECTION OF YOUR PLAN BOOKLET.**

1. Employees must complete Part A.
2. Have your doctor complete Part B.

PART A		EMPLOYEE'S STATEMENT			MUST BE COMPLETED BY EMPLOYEE			PLEASE PRINT			
1. EMPLOYEE NAME				2. BIRTH DATE			3. SOCIAL SECURITY #				
				MO.	DAY	YR.					
4. ADDRESS <input type="checkbox"/> CHECK HERE IF NEW ADDRESS			CITY	STATE	ZIP	5. PHONE NO.					
6. EMPLOYER				7. ADDRESS			8. PHONE NO.				
9. SPOUSE'S NAME		9A. BIRTH DATE		10. SPOUSE'S EMPLOYER			11. PHONE NO.				
		MO.	DAY	YR.							
12. DOES YOUR SPOUSE'S EMPLOYER OFFER YOUR SPOUSE GROUP HEALTH MEDICAL PLAN INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO											
IF YES - HAS YOUR SPOUSE ENROLLED IN THAT COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO											
13. CLAIM IS FOR:		<input type="checkbox"/> SPOUSE		14. DEPENDENT'S NAME			14A. RELATIONSHIP		15. BIRTH DATE		
<input type="checkbox"/> SELF		<input type="checkbox"/> CHILD							MO.	DAY	YR.
16. IS DEPENDENT CHILD A STUDENT AGE 19 OR OLDER? <input type="checkbox"/> YES <input type="checkbox"/> NO											
IF YES - YOU MUST ATTACH COPY OF STUDENT'S SCHOOL REGISTRATION FORM											
17. IS THIS CLAIM FOR AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		18. IF YES - WHERE DID IT HAPPEN?				18A. WHEN?			19. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO		
						MO.	DAY	YR.			
20. DESCRIBE WHAT HAPPENED											
21. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:											
I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form.											
I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.											
Employee Signature: X _____				Date _____			_____				
CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE							MO.	DAY	YR.		

QUESTIONS? PHONE (602) 249-3582

TOLL FREE 1-800-474-3485

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