

UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS

Arizona Health & Welfare Trust

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

BILLING STATEMENT (#108-15)

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.**
 (If you have already filed form 108-15 for the current year, you may use Claim Envelope, Form 108-16 instead)
- 2. Have your doctor complete Part B.**
 (Your doctor's own itemized statement form may be substituted if it contains all of the needed information)
- 3. HAVE YOUR EMPLOYER COMPLETE PART C ONLY IF YOU ARE FILING FOR DISABILITY BENEFITS.**

PART A	EMPLOYEE'S STATEMENT	MUST BE COMPLETED BY EMPLOYEE	PLEASE PRINT
1. EMPLOYEE NAME		2. BIRTH DATE MO. DAY YR.	3. SOCIAL SECURITY NO.
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 MO. DAY YR.	10. SPOUSE'S EMPLOYER	11. PHONE NO.
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 <input type="checkbox"/> SELF	<input type="checkbox"/> CHILD	14. DEPENDENT'S NAME	14A. RELATIONSHIP
			15. BIRTH DATE 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? MO. DAY YR.	19. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO
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 SE HABLA ESPAÑOL



