CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE TRUST

EMPLOYEE STATEMENT

☐ **Check here if your address is new.**

PART 1 – EMPLOYEE INFORMATION

EMPLOYEE NAME – First / Initial / Last	☐ M ☐ F	EMPLOYEE WPAS ID # OR SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE Mo. Day Year

HOME ADDRESS STREET	CITY	STATE	ZIP	PHONE

EMPLOYED BY	LOCAL NO.

PATIENT'S NAME – First / Initial / Last	☐ M ☐ F	PATIENT ID # OR SOCIAL SECURITY NO.	PATIENT BIRTHDATE Mo. Day Year	RELATION TO EMPLOYEE ☐ Self ☐ Spouse ☐ Child

EMPLOYEE MARTIAL STATUS	IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE THEIR RELATIONSHIP TO YOU	IF DEPENDENT CHILD IS AGE 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT?
☐ MARRIED ☐ LEGAL SEP. ☐ SINGLE ☐ WIDOWED ☐ DIVOCED	☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐ OTHER (EXPLAIN) _____	☐ YES ☐ NO NAME OF SCHOOL _____ IF "NO", DOES CHILD HAVE A DEVELOPMENTAL DISABILITY OR PHYSICAL HANDICAP? ☐ YES ☐ NO

NAME OF SPOUSE (if no patient listed above)	SPOUSE BIRTHDATE Mo. Day Year	SPOUSE ID # OR SOCIAL SECURITY NO.

IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME & ADDRESS SPOUSE'S EMPLOYER

PART 2 – INSURANCE INFORMATION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER GROUP INSURANCE PLAN? ☐ YES ☐ NO

IF "YES", GIVE NAME AND ADDRESS OF OTHER CARRIER NAME _____ ADDRESS_____

NAME OF SUBSCRIBER _____ SUBSCRIBER ID # OR SOCIAL SECURITY NO. _____

OTHER GROUP PLAN COVERS: ☐ PATIENT ☐ SPOUSE ☐ CHILDREN OTHER GROUP PLAN POLICY OR I.D. NO. _____

OTHER GROUP PLAN INCLUDES: ☐ MEDICAL ☐ DENTAL ☐ VISION

ARE YOU OR YOUR DEPENDENTS COVERED UNDER MEDICARE? ☐ YES ☐ NO IF YES

NAME OF PERSON COVERED _____

MEDICARE EFFECTIVE DATE _____

PART 3 – ACCIDENT/INJURY INFORMATION

WAS VISION CARE REQUIRED BECAUSE OF AN INJURY? ☐ YES ☐ NO DID ACCIDENT OCCUR WHILE AT WORK? ☐ YES ☐ NO

DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____

HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? ☐ YES ☐ NO IF "YES", GIVE CLAIM NUMBER _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his or her services but not to exceed the reasonable and customary charge for those services. Do not sign if bills have been paid.

Employee Signature _____ Date _____

I hereby certify that the foregoing statements, including any accompanying statements, are true and correct and complete to the best of my knowledge, and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. A photocopy of this authorization is as valid as the original.

Patient Signature (if not minor child) _____

Employee Signature _____ Date _____

PROCEDURE FOR FILING A CLAIM

1. Complete all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
2. Attach an itemized bill for all charges relating to this claim **or have Physician complete reverse side of this form.**
3. Complete a separate form for each patient.
4. **Mail completed form and itemized bill to:**

CEMENT MASONS & PLASTERERS
P.O. BOX 34964
SEATTLE, WASHINGTON 98124-1964
PHONE: (206) 441-7574 OR (800) 331-6158

To insure prompt payment submit only itemized bills. An itemized bill is the actual bill from the provider showing: a) date of service; b) diagnosis; c) procedure done and d) cost of each procedure. A "balance due" or non-itemized bill is NOT acceptable.

If you have other Group Insurance or Medicare as your primary coverage you need to submit the itemized bill AND a copy of the matching insurance or Medicare payment explanation.

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	AGE

DIAGNOSIS AND CONCURRENT CONDITIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

1. HAS PATIENT WORN EYEGLASSES BEFORE THIS EXAMINATION? _____ TYPE_____
   IF "YES", STATE REASON FOR REPLACMENT _____
2. IF YOU PRESCRIBED EYEGLASSES, CHECK TYPE: ☐ SINGLE VISION ☐ BIFOCAL ☐ TRIFOCAL ☐OTHER (DESCRIBE)
3. HAS CATARACT SURGERY BEEN PERFORMED? ☐ YES _____ ☐ _____ ☐ DATE _____
4. CAN VISUAL ACUITY BE RESORTED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYEGLASSES? _____
5. ARE EXISTING FRAMES BEING SUED FOR THE NEW ELEGLASSES? ☐ YES ☐ NO IF "NO", WHY NOT? _____

PROCEDURE CODES	DATES OF SERVICE	AMOUNT OF CHARGE			
ATTACH ITEMIZED BILLS	SUBTOTAL				
	TAX				
	TOTAL				

COMMENTS:

DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO IF "YES", PLEASE IDENTIFY

_____

SIGNATURE BY DOCTOR CERTIFIES THAT ALL SERVICES LISTED ABOVE HAVE BEEN COMPLETED

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE

STREET ADDRESS	CITY – STATE – ZIP CODE	INDIVIDUAL PRACTITIONERS TIN OR SS NO.

SEE OTHER SIDE FOR INSTRUCTIONS

BENEFIT, CLAIMS PAYMENT AND ELIGIBILITY INFORMATION
MAY BE OBTAINED FROM:
WELFARE & PENSION ADMINISTRATION SERVICE, INC.
PHONE: (206) 441-7574 or (800) 331-6158