

2026 CLAIM FORM

FOR HEALTH CARE BENEFITS

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CLAIM FORM MUST BE SIGNED AND DATED ON PAGE 2 FOR BENEFITS TO BE PAID

A. EMPLOYEE INFORMATION

Name: _____ ☐ Male ☐ Female
Social Security Number: _____
Mailing Address: _____
City: _____ State: _____ ZIP: _____
Telephone –Home: _____ Work: _____
Age: _____ Birthdate: _____
Local Union: _____ Employer: _____
Email Address: _____

B. SPOUSE INFORMATION

Name: _____
Social Security Number: _____
Age: _____ Birthdate: _____
*Employer: _____
Employer Address: _____
Employer Telephone: _____
Full Time: _____ Part Time: _____
Phone Number: _____

***Complete Section D if Spouse is Employed or if Other Insurance is available.**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Date of Divorce or Legal Separation _____

C. FAMILY INFORMATION

	NAME	SOCIAL SECURITY # REQUIRED	AGE 19 TO 26 Employer Name, Address & Telephone #	Other insurance? (If Yes, Complete Section D)	BIRTHDATE	SEX
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		

****PLEASE USE REVERSE SIDE FOR ADDITIONAL DEPENDENTS**

D. PLEASE COMPLETE THE SECTION BELOW FOR SPOUSE OR IF OTHER INSURANCE IS AVAILABLE

DO YOU CARRY A SEPARATE AIR AMBULANCE (AIR EVAC) POLICY? ☐ YES ☐ NO **IF YES, LIST PROVIDER:** _____

PLEASE SEE REVERSE SIDE. THE FRONT AND BACK OF THIS FORM MUST BE COMPLETED.

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MEDICAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO PRESCRIPTION DRUG CARD <input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO
Insurance Company Name:	Insurance Company Name:
Telephone: Date Coverage Began:	Telephone: Date Coverage Began:
Family Members Covered:	Family Members Covered:
Policyholder Name:	Policyholder Name:
Relationship:	Relationship:
Identification Number:	Identification Number:

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish payor of this claim or their duty authorized representative with full information regarding treatment rendered (including copies of their records). I/We also authorize any union, trust fund, employer, or insurance carrier to furnish payor of this claim or their duty authorized representative with information regarding benefits to which I/we may be entitled. (If claim for spouse, spouse also must sign.) A copy or photocopy of this authorization shall be considered as effective and valid as the original.

CLAIM FORM MUST BE SIGNED AND DATED

Date	Spouse's Signature	Member Signature
	X	X

	NAME	SOCIAL SECURITY # REQUIRED	AGE 19 TO 26 Employer Name, Address & Telephone #	Other insurance? (If Yes, Complete Section D)	BIRTHDATE	SEX
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		