SOUTHERN ILLINOIS LABORERS' & EMPLOYERS
HEALTH & WELFARE FUND
5100 ED SMITH WAY, STE A; MARION IL 62959
www.silehw.org
1-618-998-1300
CLAIMS DEPARTMENT FAX 1-618-993-8295

2015 CLAIM FORM

FOR HEALTH CARE BENEFITS

A. EMPLOYEE INFORMATION

Name:______________________ ☐ Male ☐ Female

Social Security Number:______________________

Mailing Address:______________________

City:__________ State:__________ ZIP:__________

Telephone –Home:__________ Work:__________

Age:__________ Birthdate:__________

Employer:______________________

Email Address:______________________

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

Date of Divorce or Legal Separation__________

B. SPOUSE INFORMATION

Name:______________________

Social Security Number:______________________

Age_______ Birthdate:__________

*Employer:______________________

Employer Address:______________________

Employer Telephone:______________________

Full Time:_______ Part Time:__________

****Complete Section D If Spouse is Employed***

C. FAMILY INFORMATION

	NAME	SOCIAL SECURITY # REQUIRED	AGE 19 TO 26 Employer Name, Address & Telephone #	Other Insurance Available?	BIRTHDATE	SEX
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		
CHILD				YES NO		

D. PLEASE COMPLETE THE SECTION BELOW FOR SPOUSE

MEDICAL INSURANCE ☐ YES ☐ NO DRUG CARD ☐ YES ☐ NO	DENTAL INSURANCE ☐ YES ☐ NO
Insurance Company Name:	Insurance Company Name:
Telephone:	Telephone:
Family Members Covered:	Family Members Covered:
Policyholder Name:	Policyholder Name:
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 duly 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 duly 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