Local 102 Claim Form



Fabian & Byrn, LLC T/P/A IBEW Local 102 Welfare Fund 425 Eagle Rock Avenue, Suite 105 Roseland, NJ 07068 P: 888-423-9102 F: 973-228-4295

	Member's Name (print in full)					Group #		Member ID#			
					76147		BEW				
Home Address				Date of Birth		Daytime	Daytime Phone #				
					N	Iarital Status			Work Sta	tus	
						(circle one)			(Circle Or	•	
					Single	Marrie	ł	Active		Disabled	
					Divorced	Widow	ed	Retired		Other (spec	cify)
PATIENT INFORMATION							SPC	OUSE INFOR	MATION		
Name			Date of Bi	rth		Name			-	Date of Birt	:h
l											
	Relationship to	Member		Sex		Employer Name	and Address			Employme	ent Status
Self	Spouse Child	Other (specify	Male		Female					Active Unemp	Retired
		Describe	emergency	and/or ac	cident inclu	ding how and who	re it hannen	he		onem	bioyeu
Data siskaa	se linium bagan	Did inium occur	at work	Wassisk		hu wash2	Was init	up: caucad b	au automok	Strabias Alia	
Date sicknes	ss/injury began	Did injury occur	at work	Was sick	kness caused	by work?	Was inju	iry caused b	by automok	pile accident? Y	
Date sicknes	ss/injury began	Did injury occur Y	at work	Was sick	ness causec		Was inju			bile accident? Y	N
			Ν	Y	N	, If so,	olease provid	e police repo	ort		
IF YOU OR A Covered Fan	ANY MEMBER OF mily Member (Circle	Y YOUR FAMILY IS COVER	Ν	Y	N GROUP HEA	, If so,	blease provide	e police repo	ort		
IF YOU OR A Covered Fan	ANY MEMBER OF	Y YOUR FAMILY IS COVER	Ν	Y	N GROUP HEA	If so,	blease provide	e police repo	ort		
IF YOU OR A Covered Fan S	ANY MEMBER OF mily Member (Circle self	Y YOUR FAMILY IS COVER e One) Patient	N ED UNDER	Y ANOTHER	N GROUP HEA	If so,	blease provide	e police repo	ort		
IF YOU OR A Covered Fan S S	ANY MEMBER OF mily Member (Circle self	Y YOUR FAMILY IS COVER	N ED UNDER	Y ANOTHER	N GROUP HEA Name and	If so,	blease provide	e police repo	ort		
IF YOU OR A Covered Fan S	ANY MEMBER OF mily Member (Circle self	Y YOUR FAMILY IS COVER e One) Patient Other (specify name and	N ED UNDER	Y ANOTHER	N GROUP HEA Name and	If so,	blease provide	e police repo	ort		
IF YOU OR A Covered Fan S S Policy or Pla ANY PERSOI	ANY MEMBER OF mily Member (Circle Self Spouse nn No. N WHO KNOWING	Y YOUR FAMILY IS COVER 2 One) Patient Other (specify name and Insurance I.D # SLY AND WITH INTENT	N ED UNDER d relationship) TO DEFRAU	Y ANOTHER Type of cc individual D ANY INS	N GROUP HEA Name and Name and Diverage Family URANCE CO	If so, ILTH PLAN, COMP address of Insurar MPANY FILES A ST	olease provid. <u>ETE THE FOL</u> ce Company CATEMENT OF	e police repo LOWING SE	ort CTION	Y 	
IF YOU OR A Covered Fan S Policy or Pla ANY PERSOI MATERIALLY	ANY MEMBER OF mily Member (Circle self in No. N WHO KNOWING Y FALSE INFORMA	Y YOUR FAMILY IS COVER Patient Other (specify name and Insurance I.D # SLY AND WITH INTENT TION, OR CONCEALS FO	N EED UNDER d relationship) TO DEFRAU DR THE PUR	Y ANOTHER Type of cc individual D ANY INS	N GROUP HEA Name and Name and Diverage Family URANCE CO	If so, ILTH PLAN, COMP address of Insurar MPANY FILES A ST	olease provid. <u>ETE THE FOL</u> ce Company CATEMENT OF	e police repo LOWING SE	ort CTION	Y 	
IF YOU OR A Covered Fan S Policy or Pla ANY PERSOI MATERIALLY COMMITS A	ANY MEMBER OF mily Member (Circle self in No. N WHO KNOWING Y FALSE INFORMA A FRAUDULENT IN	Y YOUR FAMILY IS COVER Patient Other (specify name and Insurance I.D # SLY AND WITH INTENT TION, OR CONCEALS FO SURANCE ACT, WHICH IS	N EED UNDER d relationship) TO DEFRAU DR THE PUR S A CRIME.	Y ANOTHER Type of cc individual D ANY INS POSE OF N	N GROUP HEA Name and Name and Diverage Family URANCE CO VISLEADING	If so, ILTH PLAN, COMP address of Insurar MPANY FILES A ST , INFORMATION C	olease provid <u>ETE THE FOL</u> ce Company CATEMENT OF ONCERNING	e police rep LOWING SE CLAIM COI ANY FACT N	ort CTION MTAINING A	Y ANY THERETO,	
IF YOU OR A Covered Fan S Policy or Pla ANY PERSOI MATERIALLY COMMITS A AUTHORIZATI	ANY MEMBER OF mily Member (Circle self in No. N WHO KNOWING Y FALSE INFORMA A FRAUDULENT IN ION FOR RELEASE OF	Y YOUR FAMILY IS COVER Patient Other (specify name and Insurance I.D # SLY AND WITH INTENT TION, OR CONCEALS FO	N EED UNDER d relationship) TO DEFRAU DR THE PUR S A CRIME. horize the re	Y ANOTHER Type of cc individual D ANY INS POSE OF N lease to ULL	N GROUP HEA Name and Name and Deverage Family URANCE CO MISLEADING	If so, I ITH PLAN, COMP address of Insurar MPANY FILES A ST , INFORMATION C ents of any evidence	Dease provid <u>ETE THE FOL</u> ce Company ATEMENT OF ONCERNING or information	e police rep LOWING SE CLAIM COI ANY FACT N about me or	ort CTION NTAINING A MATERIAL T	Y ANY THERETO,	
IF YOU OR A Covered Fan S Policy or Pla ANY PERSOI MATERIALLY COMMITS A AUTHORIZATI	ANY MEMBER OF mily Member (Circle self in No. N WHO KNOWING Y FALSE INFORMA A FRAUDULENT IN ION FOR RELEASE OF	Y YOUR FAMILY IS COVER 2 One) Patient Other (specify name and Insurance I.D # SLY AND WITH INTENT TION, OR CONCEALS FO SURANCE ACT, WHICH IS INFORMATION: I/We aut	N EED UNDER d relationship) TO DEFRAU DR THE PUR S A CRIME. horize the re	Y ANOTHER Type of cc individual D ANY INS POSE OF N lease to ULL	N GROUP HEA Name and Name and Deverage Family URANCE CO MISLEADING	If so, I ITH PLAN, COMP address of Insurar MPANY FILES A ST , INFORMATION C ents of any evidence	Dease provid <u>ETE THE FOL</u> ce Company ATEMENT OF ONCERNING or information	e police rep LOWING SE CLAIM COI ANY FACT N about me or	ort CTION NTAINING A MATERIAL T	Y ANY THERETO,	

* Please attach medical claim form and proof of payment for reimbursement.

Check	one:

I authorize payment of medical benefits directly to the below named Doctor, Provider or Supplier. Authorizations will be honored only if a valid Tax Identification Number for the provider is shown on the claim form.

Benefits should be paid directly to me.