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 Phone #
	Marital Status (circle one) Single Married Divorced Widowed	Work Status (Circle One) Active Disabled Retired Other (specify)

PATIENT INFORMATION		SPOUSE INFORMATION	
Name	Date of Birth	Name	Date of Birth
Relationship to Member Self Spouse Child Other (specify	Sex Male Female	Employer Name and Address	Employment Status Active Retired Unemployed

Describe emergency and/or accident including how and where it happened

Date sickness/injury began	Did injury occur at work	Was sickness caused by work?	Was injury caused by automobile accident?
	Y N	Y N	Y N If so, please provide police report

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION

Covered Family Member (Circle One)	Name and address of Insurance Company
Self Patient Spouse Other (specify name and relationship)	

Policy or Plan No.	Insurance I.D #	Type of coverage individual Family

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT,WHICH IS A CRIME.

AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to ULLICO and its agents of any evidence or information about me or my dependent(s) that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original. (Patient's signature is required if patient is a legal adult)

Member's Signature Date

Patient's Signature Date

* 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.**

Member's Signature Date