

St. Louis Graphic Arts Joint Health & Welfare Fund

c/o Benefit Consultants, Inc.
13515 Barrett Parkway Drive, Suite 265
Ballwin, MO 63021

We have received a claim for benefits. The diagnosis given by the provider indicates a possible condition that may or may not be related to an accident/injury. Please complete the following questionnaire so that we may process your claim.

Participant's Name: _____ Participant's Social Security No. _____

Patient's Name: _____ Patient's Date of Birth: _____

Date/time of onset: _____ Place of onset: _____

Fully describe the details of the injury/accident: _____

If a covered person is entitled to medical benefits under this plan by reason of sickness or injury resulting from the negligent or wrongful conduct of another (third) party, this Fund shall be subrogated to the rights of recovery which the covered person may have against any person. (Example: motor vehicle accident, animal bite, assault, injury on either someone's private property or commercial property). Refer to Page 108 Section 7.9 & 7.10 in the Summary Plan Description.

If a third party is involved, provide name, address and phone number of third party:

Name, address and phone number of any other insurance that may have a liability in this matter:

If represented by legal counsel in this matter, please list the name, address and phone number of your attorney:

If a police report was filed, please obtain a copy and submit with this completed questionnaire.

The employee and dependent have an obligation to diligently pursue recovery of benefits from such other source. If an employee or dependent fails to do so, this Fund shall have no obligation to provide benefits. To the extent that this Fund may have already provided benefits the employee and dependent shall be obligated to return such benefits to this Fund. Refer to Page 86 Section 4.16 in the Summary Plan Description.

I certify that the above information is true and correct.

Signature of Patient or Parent if Minor

Date