

YEARLY MEDICAL CLAIM FORM
ST. LOUIS GRAPHIC ARTS JOINT HEALTH & WELFARE FUND

THIS FORM MUST BE COMPLETED IN FULL BY PARTICIPANTS AND RETURNED TO

BENEFIT CONSULTANTS, INC
13515 BARRETT PARKWAY DR., SUITE 265 BALLWIN, MO 63021
(314) 822-7890 OR (800) 434-4620

Participant's Last Name	First Name	M.I.	Participant's Social Security #	Date of Birth	Sex M F
Home Street Address			Home Phone #		
City	State	Zip	Employer Name		

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH DEPENDENT COVERED BY THIS PLAN

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	DATE OF BIRTH	SEX	ENROLLED IN MEDICARE?	ENROLLED IN OTHER GROUP COVERAGE? **	ADDRESS IF DIFFERENT FROM EMPLOYEE'S
				SPOUSE			? YES ? NO	? YES ? NO	
				CHILD			? YES ? NO	? YES ? NO	
				CHILD			? YES ? NO	? YES ? NO	
				CHILD			? YES ? NO	? YES ? NO	
				CHILD			? YES ? NO	? YES ? NO	
				CHILD			? YES ? NO	? YES ? NO	
				CHILD			? YES ? NO	? YES ? NO	

**** If you answered yes to enrolled in other Group Coverage, please complete the following section in full**

Other Group Coverage Carrier	Effective Date	Subscriber Name	Policy Number	Indicate Person Or Persons Covered

IF DIVORCED, WHOM DO THE CHILDREN LIVE WITH? _____

IS THERE A COURT ORDER ASSIGNING MEDICAL RESPONSIBILITY TO ONE OF THE PARENTS? ? YES ? NO **IF YES, PLEASE STATE THE FULL NAME OF THE PERSON WHO HAS MEDICAL RESPONSIBILITY ORDERED BY THE COURTS** _____ **PLEASE SEND A COPY OF THE DIVORCE DECREE.**

BENEFITS ARE AUTOMATICALLY ASSIGNED UNLESS THERE IS PROOF FILED THAT THE BILL HAS BEEN PAID IN FULL. TO PREDETERMINE MEDICAL NECESSITY, CONTACT HEALTHLINK, INC. THIS FORM SHOULD NOT BE USED FOR PERSCRIBING DRUG CLAIMS.

PARTICIPANT AND SPOUSE PLEASE SIGN BELOW

CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSIFICATION OR WITHHOLDING OF MATERIAL FACTS MAY RESULT IN LOSS OF BENEFITS AND OTHER SERIOUS CONSEQUENCES.

FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR BENEFITS AND CLAIM PROCESSING, I HEREBY AUTHORIZE THIS TRUST FUND AND ITS AGENTS TO RECEIVE FROM AND PROVIDE TO MEDICAL PRACTITIONERS, MEDICAL-RELATED FACILITIES, INSURANCE COMPANIES, OTHER HEALTH PLANS AND OTHER PARTIES INVOLVED IN CLAIMS PROCESSING INFORMATION AS TO ANY PHYSICAL OR MENTAL CONDITION OF MYSELF OR MY COVERED DEPENDENTS. I AGREE THAT THE FUND MAY OBTAIN AN EMPLOYEE CREDIT REPORT. I KNOW THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY IS AS VALID AS THE ORIGINAL

PARTICIPANT'S SIGNATURE	SPOUSE'S SIGNATURE	DATE
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IT IS THE RESPONSIBILITY OF THE PARTICIPANT TO NOTIFY BENEFIT CONSULTANTS, INC. IF CHARGES ARE INCCURED ANY TIME DURING THE YEAR DUE TO A WORKERS COMPENSATION CLAIM OR OTHER TYPE ACCIDENT.

