United Food and Commercial Workers
Union and Employers Calumet Region Insurance Fund
1431 Opus Place, Suite 350
Downers Grove, IL 60515

Phone: (847) 720-0008
Fax: (847) 384-0197
Toll Free: (800) 621-5133
www.ufcwbenefitfunds.com

Initial Report of Claims

Instructions: This form is to be completed by the member. Complete member's section fully. Be sure to include your Social Security Number and sign member's signature section. Remember to attach itemized bills.

NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY

MEMBERS COMPLETE THIS SECTION:

Full Name of Member

Phone Number & Email

Date of Birth & SSN#

Occupation

Employer

Home Address

Street Address | Street Address Line 2

City | State | Postal/Zip Code

If claim is for member's disability, show date last worked:

Date resumed work

COMPLETE THIS SECTION IF CLAIM IS FOR DEPENDENT:

Full Name of Dependent

Relationship to Member & Date of Birth

Is Dependent Employed?

- ◯ Yes, state name of Employer:
- ◯ No

Is the Patient Covered by Any Other Insurance, Prepaid Health Plan, Medicare or Other Governmental Plan?

- ◯ Yes
- ◯ No

Insured's Name

Group Insurance Company or Plan's Name

Policy Number

Group Insurance Company or Plan's Address

Street Address

City | State | Postal/Zip Code

Full Name of Spouse

Spouse's Date of Birth & SSN#

COMPLETE THIS SECTION FOR ALL CLAIMS:

Nature of Sickness or Injury

Date Accident Occurred or Sickness Began

Date First Treated

If Hospitalized, Name of Hospital

Date Admitted & Date Discharged

Did someone intentionally cause this injury? ◯ Yes ◯ No

Was injury due to an accident? ◯ Yes ◯ No

Did the accident happen on your property?

◯ Yes

◯ No, Address where accident occurred:

Was this due to an auto accident? ◯ Yes ◯ No

Did injury or illness occur in the course of employment? ◯ Yes ◯ No

Have you filed this under Workers' Compensation? ◯ Yes ◯ No

Have you started a lawsuit related in any way to this injury/illness? ◯ Yes ◯ No

Have you received any settlement, payment, recovery of benefits, including insurance company policy, related in any way to this injury/illness? ◯ Yes ◯ No

Have you hired an attorney to represent you regarding this claim? ◯ Yes ◯ No

I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physician to release information concerning my enrollment, related records and medical records to the Fund.

Insured Member's Signature

Date

Return Completed Form to: **UFCW Benefits Fund Office**
c/o Wilson-McShane Corporation
1431 Opus Place, Suite 350
Downers Grove, IL 60515