

UNION CONSTRUCTION WORKERS

HEALTH PLAN

**P.O. Box 697
Toledo, Ohio 43697-0697
419-248-2401**

**CLAIM FORM
ELIGIBILITY ASSISTANCE PROGRAM
PERSONAL ACCOUNT PLAN**

Dear Member:

FOR PROMPT HANDLING OF YOUR CLAIM,
HAVE THIS COMPLETED FORM RETURNED
TO THE ABOVE ADDRESS AT THE EARLIEST
POSSIBLE TIME

1. Member Social Security No. _____ Local Union No. _____

2. Claim is for (name) _____ Relationship _____

3. Following is item(s) for which I have not been reimbursed under any other program of insurance and for which I am requesting payment under my Personal Plan Account.

_____ Unreimbursed Prescription Drugs – may include Co-Pay

_____ Unreimbursed Dental Expenses

_____ Unreimbursed Corrective Eye Glasses or Contact Lenses

_____ Unreimbursed Expenses for treatment of Alcohol-Drug or Mental Nervous Disorders.

_____ Unreimbursed Chiropractic Expenses

_____ Unreimbursed Ambulance Service

_____ Unreimbursed Diagnostic or Laboratory Fees.

_____ Deductibles or Co-Payments applied to cover medical expenses under UCW or under COB provisions

_____ Eligibility Assistance to maintain coverage due to a termination notice from UCW.

_____ Other expense allowable under the Internal Revenue Code for this type of plan. (Attach an explanation)

IMPORTANT:

You must submit your Health Plan Explanation of Benefits (EOB) Form with this claim form to receive reimbursement. For allowable bills under the Federal Tax code not covered by your Health Plan, an itemized bill is required.

I hereby authorize payment for the above services for which I am requesting benefits made:

Payable to Provider

Payable to me

A \$2.00 Administrative Charge will be deducted from the Personal Account Plan for each issued worksheet.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I understand that this claim is submitted under the Eligibility Assistance Program and Personal Account Plan provisions of the Union Construction Workers Health Plan of which I have and/or am entitled to receive a written description. Further, that if my Personal Account Plan is not sufficient to provide payment for the bill submitted, partial payment will be made such that my account will be reduced to zero.

Date: _____

Member's Signature: _____