

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
 email: claims@fabianbyrn.com

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	Is another party responsible	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 _____		Patient's Signature _____	
Date _____		Date _____	

*** Please attach medical claim form and proof of payment for reimbursement.**

Check one: <input type="checkbox"/> 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. <input type="checkbox"/> Benefits should be paid directly to me.	Member's Signature _____ Date _____
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