IBEW Local 347 Electrical Workers Health and Welfare Fund

P.O. Box 26068
Salt Lake City, UT 84126-0068

CompuSys of Utah, Inc.

Toll Free (844) 347-IBEW (4239)
Fax (801) 973-1007

STATEMENT OF CLAIM

PARTICIPANT STATEMENT

1. Name of Participant	2. Social Security Number	3. Date of Birth	4. Sex ❑ M ❑ F
5. Home Street Address	City	State	Zip
6. Home Phone / Cell Phone Number	7. Business Phone Number		
8. Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Patient Is ❑ Self ❑ Spouse ❑ Child	**IF CLAIM IS FOR YOUR SPOUSE OR CHILD, PLEASE COMPLETE THE APPROPRIATE SECTION BELOW.**	Custody of Child ❑ Yes ❑ No
Are you insured under any other group, government, employer, or other insurance plan? ❑ Yes ❑ No			
If yes, provide the name, address, policy number, and phone number of the insurance company.			

SPOUSE STATEMENT

1. Name of Spouse	2. Social Security Number	3. Date of Birth	4. Sex ❑ M ❑ F	Cell Phone Number
5. Address if different than above	City	State	Zip	
6. Is Spouse Employed? ❑ Yes ❑ No	If yes, name and address of employer	Employer Phone Number		
Are you insured under any other group, government, employer, or other insurance plan? ❑ Yes ❑ No				
If yes, provide the name, address, policy number, and phone number of the insurance company.				

CHILD STATEMENT

1. Name of Child	2. Social Security Number	3. Date of Birth	4. Sex ❑ M ❑ F	Phone Number
5. Address if different than above	City	State	Zip	
6. Is Child / Dependent Employed? ❑ Yes ❑ No	If yes, name and address of employer	Employer Phone Number		
Are you insured under any other group, government, employer, or other insurance plan? ❑ Yes ❑ No				
If yes, provide the name, address, policy number, and phone number of the insurance company.				

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OR SERVICE PROVIDER.

SIGNATURE OF PARTICIPANT: _____

DATE: _____

THE FOLLOWING IS EXTREMELY IMPORTANT INFORMATION. PLEASE READ THIS LANGUAGE CAREFULLY AND THEN SIGN AND DATE THIS STATEMENT OF CLAIM FORM AND RETURN IT TO THE FUND OFFICE.

I hereby certify that all information provided on this Statement of Claim Form is correct to the best of my knowledge. I understand that if this information changes, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the IBEW Local 347 Electrical Workers Health and Welfare Fund for any payments made as a result of my failure to notify the Fund Office of a change in the information provided on this Statement of Claim Form.

SIGNATURE OF PARTICIPANT: _____

DATE: _____