# Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund

## Initial Report of Claims Disability

**GROUP**
**76-580060**

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

**INSTRUCTIONS:**

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

**RETURN COMPLETED FORM TO:**


**Greater Metropolitan Hotel Employers-Employees**
**Health and Welfare Fund**
3001 Metro Drive - Suite 500
Bloomington, MN 55425
952-854-0795 | Fax 952-851-3521 | Toll Free 1-800-535-6373


### Member Completes This Section:

| Name of Member | | | Home Phone | |
|---|---|---|---|---|
| Date of Birth | Social Security Number | | Occupation | |
| Employer | | | | |
| Home Address | City | | State | Zip Code |
| If claim is for member's disability, show date last worked: | | | Date resumed work: | |

### 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**
If 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 claim under Workmen's 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 or benefits, including insurance company or 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 Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund.**

Insured Member's Signature ______________________________ Date __________

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## INSTRUCTIONS:

### ATTENDING PHYSICIAN'S STATEMENT

This form does not have to be completed, **if** you can furnish the Administrator with a complete itemized and coded statement of services from the doctor.

If you do not have a complete itemized and coded statement, your physician may use this form to report his/her services and charges.

### DISABILITY

To collect disability benefits, your physician must complete questions, 1, 2, 4, 5, 7, 8, and 9 and sign and date this form.

### ATTENDING PHYSICIAN'S STATEMENT:

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name).

2. Is the condition due to injury or sickness arising out of patient's employment?

Is condition due to pregnancy? If Yes, approximate date pregnancy commenced.
❐ YES ❐ NO

3. Report of services (or attach itemized bill. If previous form submitted to this carrier, you need show only dates and services since last report).

| Date of Services | Place of Services | Description of Surgical or Medical Services Rendered | Procedure code - If used If code other than CPT used, give name | Charges | **Office Use Only** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

+O = Doctor's Office IH = Inpatient Hospital
H = Patient's Home OH = Outpatient Hospital
NH = Nursing Home OL = Other Location
ICDA = International Classification of Diseases
CPT = Current Procedure Terminology (current location)

Total Charges $______________
Amount Paid $______________
Balance Due $______________

4. Date symptoms first appeared or accident happened.

5. Date patient first consulted you for this condition.

6. Has patient ever had same or similar condition? if yes, when and describe.

7. Is patient still under your care for this condition? ❐ YES ❐ NO

8. Patient was continuously totally disabled (unable to work).
From Thru

9. Date patient should be able to return to work, if still disabled.

10. Does patient have other heath coverage? If Yes, please identify
❐ YES ❐ NO

Taxpayers identification number:

| Print Physician's Name | Physician's Signature | Degree | Date |
|---|---|---|---|
| | | | |

Street address

Telephone
( )

| City | Providence | State | Zip Code |
|---|---|---|---|
| | | | |

### MEMBERS ASSIGNMENT (PLEASE READ BEFORE SIGNING)

**To be completed and signed by the Member if direct payment by fund to surgeon or physician is desired.** (This assignment may not be honored if signed by a dependent or person other than the Insured Member).

**I hereby authorize the Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund to pay directly to the above named hospital or physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy.**

Insured Member's Signature Signed ______________________________ Date ____________