Operating Engineers' Local No. 428 Health & Welfare Trust Fund

P.O. Box 43110, Phoenix, AZ 85080-3110 | Toll Free: (800) 474-3485 Fax: (480) 302-2237
www.SSATPA.com

Health Claim Form

Please note!

- This form is to be completed by the plan participant once every 12 months to inform the trust fund of changes in family status or the addition of other medical insurance.
- The information requested will facilitate the payment of your claims. If other insurance is involved, informing the Trust Fund may save you certain out-of-pocket expenses through the coordination of benefits.

Employee Information

Full Name (First, Last)		Street Address Including City, State, and ZIP Code	
Gender	☐ Male ☐ Female	Birth Date	
Social Security Number		Phone Number	
Status	☐ Active ☐ Retiree	Marital Status	☐ Married ☐ Divorced ☐ Single ☐ Widowed
Email Address		Local Union No.	

Dependent Information

Full Name (First, Last)		Street Address Including City, State, and ZIP Code *(If different from employee's)*	
Gender	☐ Male ☐ Female	Birth Date	
Social Security Number		Phone Number	
Employed	☐ Yes ☐ No	Employment Status *(If employed)*	☐ Full-Time ☐ Part Time
If employed, Name of Employer:		Address of Employer Street Address Including City, State, and ZIP Code	
Are you insured under any other group insurance?	☐ Yes* ☐ No *if yes, please complete Other Insurance Information		

Other Insurance Information (If applicable)

Name of Company		Street Address Including City, State, and ZIP Code	
Policy Number		Effective Date	
Type of Coverage *(Check all that apply)*	☐ Family ☐ Single ☐ Medical ☐ Dental ☐ Vision		

Please sign reverse side!

Authorization

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator to provide Southwest Service Administrators, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on Southwest Service Administrators, Inc. behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness or use of drugs or alcohol. I also authorize the employer or benefit plan administrator to provide Southwest Service Administrators, Inc. with financial or employment related information. I understand this information will be used by Southwest Service Administrators, Inc. for the purpose of evaluating my claim for benefits, and I or any authorized representative will receive a copy of this signed form upon request.
I further authorize Southwest Service Administrators, Inc.to release the benefit plan administrator, a summary of claims incurred by me and my covered dependents for the purpose of verifying claims submitted under my plan of benefits. This authorization is valid from the date signed for the duration of the claim.

If patient/employee is under 18 years of age or incapacitated, parent or guardian must sign. If patient/employee is deceased, authorized representative or next of kin must sign.

Signature _____ Name _____

Signature of Custodial Parent if Medical Support Order is involved — *Name of Patient/Participant or deceased (print)*

Signature _____ Name _____

Signature of Patient/Participant, Authorized Representative or Next of Kin — *Name of the Person Submitting this Form (print)*

Date of Signature _____ _____ _____

MM *DD* *YY*

NOTICE TO ALL PARTIES

It is fraud to knowingly fill out this form with false information or to knowingly omit important facts. Criminal and/or civil penalties can result from such acts.