

SOUTHWEST ADMINISTRATORS, INC.

P O Box 1121
 Phone: (877) 350-4792
 Alhambra, California 91802-1121

4666 Mission Gorge Place #1
 Phone: (619) 287-1043
 San Diego, California 92120

P O Box 26509 Phone:
 (602) 233-3913
 Las Vegas, Nevada 89126-6509

FOR OFFICE USE ONLY

JULIAN DAY	ADJ. NO.	CLAIM NO.

**CLAIM FORM MUST BE SUBMITTED
 WITHIN 90 DAYS OF SERVICE**

ANSWER ALL QUESTIONS THAT APPLY • SIGN WHERE INDICATED

EMPLOYEE NAME		SOCIAL SECURITY NUMBER	
COMPLETE HOME ADDRESS		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
CITY	STATE	ZIP	TELEPHONE NUMBER
EMPLOYED BY		LOCAL UNION NO	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
CLAIM IS MADE FOR <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD		FIRST & LAST NAME OF CLAIMANT	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
WAS DISABILITY CAUSED BY WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU FILED A CLAIM WITH THE WORKER'S COMPENSATION CARRIER FOR THIS DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	FIRST DATE UNABLE TO WORK DATE HOUR	DATE RETURNED TO WORK <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.

GIVE THE FOLLOWING INFORMATION ABOUT YOUR SPOUSE. (MUST BE COMPLETED IN ALL CASES)

NAME _____ WAS YOUR SPOUSE EMPLOYED DURING THE PAST TWELVE MONTHS? YES NO

EMPLOYER _____ S.S. # _____ ADDRESS _____

DO YOU, YOUR SPOUSE, OR CHILD HAVE ANY OTHER GROUP INSURANCE (OTHER THAN TRUST FUND)?
 IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS FOR SELF SPOUSE CHILD STEPCHILD

INSURED	NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING BENEFITS OR SERVICES	POLICY NO. OR IDENTIFICATION NO.

WAS INJURY CAUSED BY AN ACCIDENT? YES NO IF "YES", THIS PORTION MUST BE COMPLETED

DATE OF ACCIDENT	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WAS CLAIMANT AT WORK WHEN ACCIDENT HAPPENED <input type="checkbox"/> YES <input type="checkbox"/> NO	FOR WHOM?
PLACE AND DETAILS OF ACCIDENT			

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, dentists, psychologists, pharmacists, hospitals or other institutions providing care, treatment, consultation, drugs, or supplies to furnish Trust Fund with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered - including copy of their records. I/We authorize any Insurance Carrier, service plan, union, trust fund, or employer to furnish Trust Fund with information regarding benefits to which I/We may be entitled. I/We also authorize Trust Fund to release any information relevant to a determination of the applicability of or an implementation of a Coordination of Benefits provision to any Insurance Carrier, service plan, union, trust fund or employer requesting such information. A photo static copy of this authorization shall be considered as effective and valid as the original.

DATE	SPOUSE'S SIGNATURE	EMPLOYEE'S SIGNATURE
	→	→

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Provider of service for Medical Benefits, it any, otherwise payable to me for services submitted with this claim form, but not to exceed the reasonable and customary charge for those services.



SIGNED (INSURED SIGNATURE)

DATE

INSTRUCTIONS TO EMPLOYEE

When to file a claim:

1. If you or one of your covered dependents incurs hospital, surgical or any medical expenses, file a claim as soon as expenses are incurred.
2. If your plan includes weekly disability benefits, you should file a claim if you are disabled and unable to continue working as a result of an accident or where disability due to a sickness extends beyond one week.

How to file a claim:

1. Complete front of claim form. If a question does not apply, indicate this by showing "N/A". Sign the form in the space provided where indicated. If claim is for your spouse, he or she must also sign in the space labeled "Spouses Signature".
2. Attach additional information as necessary.
3. Any bill sent separate from the claim form must be identified by showing the name of your employer and the member's social security number.
4. Be sure all questions are answered.

GROUP NUMBER REFERENCE

GROUP 101	WESTERN TEAMSTERS WELFARE TRUST (LOS ANGELES)
GROUP 102	TEAMSTERS AND FOOD EMPLOYERS SECURITY TRUST FUND
GROUP 104	WESTERN TEAMSTERS WELFARE TRUST (PHOENIX/NEW MEXICO)
GROUP 105	SOUTHERN CALIFORNIA BAKERY DRIVERS SECURITY FUND
GROUP 106	SOUTHERN CALIFORNIA DAIRY INDUSTRY SECURITY TRUST FUND
GROUP 108	TEAMSTERS MISCELLANEOUS SECURITY TRUST FUND
GROUP 127	SO. CALIFORNIA SOFT DRINK INDUSTRY AND TEAMSTERS HEALTH & WELFARE FUND