MEDICAL CLAIM FORM
FOR GROUP BENEFITS

Please mail completed form to:

JOINT BENEFIT TRUST

Phone: 800-JBT-HELP (800-528-4357)

– IMPORTANT –

TO QUALIFY FOR MAXIMUM BENEFITS YOU OR YOUR DOCTOR MUST:

- **Call Blue Cross at 1-800-274-7767** at least three (3) working days prior to an elective hospital admission or as soon as possible following an emergency admission. Maternities should be certified by the 7th month of pregnancy.

FAILURE TO CALL BLUE CROSS WILL RESULT IN A 50% REDUCTION IN BENEFITS.

The Joint Benefit Trust has also negotiated cost saving rates with certain hospitals. The Trustees urge you to use one of these preferred hospital facilities. This will reduce health plan costs and may also reduce your co-payment. Please see your employer or union for the name of a preferred hospital in your area, or call the Benefits Office at 800-JBT-HELP.

NOTE: TO INSURE PAYMENT OF HEALTH PLAN BENEFITS, THIS FORM SHOULD BE FULLY COMPLETED ON BOTH SIDES AND SUBMITTED TO THE ABOVE ADDRESS IMMEDIATELY FOLLOWING INJURY OR COMMENCEMENT OF ILLNESS.

EMPLOYEE'S NAME (First) (Last)	SOCIAL SECURITY NUMBER	☐ REGULAR (1400 HOUR) ☐ RETIRED ☐ SEASONAL (NON-1400 HOUR)
ADDRESS	EMPLOYER (CANNING INDUSTRY)	LOCAL NO.
CITY / STATE / ZIP CODE	FOR SEASONAL EMPLOYEES, NAME OF OFF-SEASON EMPLOYER (IF ANY)	

HOME TELEPHONE NO.	EMPLOYEE BIRTH DATE	CLAIM IS FOR	PATIENT'S NAME (First) (Last)	
		☐ SELF ☐ SPOUSE ☐ CHILD		☐ MALE ☐ FEMALE

PATIENT'S BIRTH DATE	IS PATIENT FULL TIME STUDENT?	IF YES, NAME OF SCHOOL ATTENDING AND CITY WHERE SCHOOL IS LOCATED
/ /	☐ YES ☐ NO	

NATURE OF ILLNESS

IF CLAIM IS FOR AN INJURY ALWAYS COMPLETE THIS SECTION

DATE OF INJURY	TIME	WAS THE PATIENT AT WORK WHEN INJURED?	DID THE PATIENT'S WORK CAUSE THIS CONDITION?	HAS CLAIM BEEN FILED WITH THE WORKER'S COMPENSATION CARRIER?
	☐ AM ☐ PM	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

HOW DID INJURY HAPPEN?

WHERE WAS THE PATIENT WHEN INJURED? | DATE RETURNED TO WORK: / /

NAME OF SPOUSE (First) (Last)	NAME AND ADDRESS OF SPOUSE'S EMPLOYER

SPOUSE IS:	SPOUSE'S BIRTH DATE	SPOUSE'S SOCIAL SECURITY NUMBER	DOES EMPLOYER OR SPOUSE HAVE OTHER GROUP INSURANCE?
WORKING ☐ RETIRED ☐	/ /		EMPLOYEE ☐ YES ☐ NO SPOUSE ☐ YES ☐ NO

NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM

THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

If the illness or injury for which I am now claiming benefits was caused by a third party, the Fund has the right to receive, and I shall pay the Fund, or assign to the Fund, any monies up to the recovery from that third party for any benefits the Fund paid because of this illness or injury.

DATE: ____/____/____ SIGN HERE

Employee's Signature

1. _____

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I authorize any medical information relating to this claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other plan administrator, and will be used for the purpose of processing this claim. This Authorization shall remain valid as long as necessary to process, pay or resolve any questions regarding this claim. Upon request, the patient shall be furnished with a copy of this Authorization.

DATE: ____/____/____ SIGN HERE

Parent's Signature (if not a minor child)

SIGN HERE

Employee's Signature

2. _____

ASSIGNMENT OF BENEFITS (SEE INSTRUCTIONS BEFORE SIGNING)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ATTENDING PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES AS DESCRIBED ON THE REVERSE SIDE BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THOSE SERVICES.

DATE: ____/____/____ SIGN HERE

Employee's Signature

3. _____

ITEMIZED BILLS MUST ACCOMPANY THIS FORM AND THE EXAMINING PHYSICIAN MUST COMPLETE THE REVERSE SIDE

REV. 9/03

Benefits are provided by the Trustees of the JOINT BENEFIT TRUST for the employees of the California Food Processing Industry