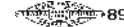




# CEMENT MASONS & PLASTERERS LOCAL UNION #518 FRINGE BENEFIT FUNDS

Managed for the Trustees by:  
**TIC INTERNATIONAL CORPORATION**  
6405 Metcalf, Suite 200 • Overland Park, Kansas 66202  
(913) 236-5490 • Fax: (913) 236-5499



## GROUP COMPREHENSIVE MEDICAL BENEFITS CLAIM FORM (INCLUDE COPY OF BILLS)

### PART 1 – PARTICIPANT COMPLETES IN ALL CASES

Name (Print): \_\_\_\_\_  
(First) (MI) (Last)

Address: \_\_\_\_\_  
(Number and Street) (City) (State) (Zip Code)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Divorced If Divorced, Date of Divorce: \_\_\_\_\_

Claim is For:  Illness  Injury  Accident\*  Pregnancy  Other: \_\_\_\_\_

**\*If Claim is for an Accident, please complete the following:**

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  AM  PM Did Accident Happen at Work?  Yes  No

How did the Accident occur? \_\_\_\_\_

Where did the Accident occur? \_\_\_\_\_

Date of First Treatment: \_\_\_\_\_ Date First Disabled: \_\_\_\_\_ Local Union Number: \_\_\_\_\_

### PART 2 – COMPLETE THIS SECTION OF CLAIM IS FOR YOUR DEPENDENT

**Dependents must meet the "Covered Dependent" Status as defined in the *Summary Plan Description*.**

Name of Dependent (Print): \_\_\_\_\_  
(First) (MI) (Last)

Relationship of Dependent to Participant: \_\_\_\_\_

Dependent is:  Single  Married  Divorced Full Time Student?:  Yes  No

### PART 3 – PARTICIPANT MUST COMPLETE IN ALL CASES OR FORM WILL BE RETURNED

Do you have any other Group Insurance (including Medicare)?:  Yes  No

If Yes, Insurance Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Spouse's Name (Print): \_\_\_\_\_ Is Your Spouse Employed?:  Yes  No

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does Spouse have other Group Insurance (including Medicare)?:  Yes  No

If Yes, Insurance Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Are You or any of your Dependents covered under any other Group Medical Plan other than shown above?  Yes  No

By signing below, I certify that the above statements are true, complete and accurate to the best of my ability and authorize any physician, hospital, employer, insurance company or other information to furnish any information necessary to consider this claim. A photocopy of this authorization shall be as valid as the original. If the claim is for a Dependent, the Dependent meets the eligibility requirements as outlined in the *Summary Plan Description*.

Participant Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_