501 Shatto Place, 5th Fl., Los Angeles, CA 90020
(800) 595-7473 (213) 385-6161
Fax:(213) 487-3640 www.scptac.org

SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
(For Active Participants & Eligible Dependents)

SOUTHERN CALIFORNIA PIPE TRADES PENSIONERS & SURVIVING SPOUSES HEALTH FUND

CLAIM FORM

(i) A new claim form is required once every calendar year.
(ii) A new claim form is required for each new injury.
(iii) This Claim Form is necessary for the Fund to determine eligibility for benefits. All questions must be answered or Claim Form will be returned. This form will NOT be valid unless signed in Part V. Failure to complete and sign this form will delay the processing of your claim.

PART I : PARTICIPANT & SPOUSE INFORMATION

	PARTICIPANT	SPOUSE (required whether or not spouse is patient)
NAME	First Last	First Last
SSN or PARTICIPANT ID (SSN only the last four digits required)		
DATE OF BIRTH	mm/dd/yy	mm/dd/yy
ADDRESS	Street City State Zip	Street City State Zip
PHONE	( ) -	( ) -
EMPLOYER NAME		
EMPLOYER ADDRESS	Street City State Zip	Street City State Zip
EMPLOYER PHONE	( ) -	( ) -

PART II : PATIENT INFORMATION

NAME	First Last	**PHONE**	( ) -
ADDRESS (if different from above)	Street City State Zip	**RELATIONSHIP TO PARTICIPANT**	( ) SELF ( ) SPOUSE ( ) DEPENDENT CHILD
		PATIENT GENDER	( ) MALE ( ) FEMALE

PATIENT MARITAL STATUS	☐ SINGLE	☐ MARRIED	☐ DIVORCED

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PART III : OTHER COVERAGE or BENEFITS

Is the patient eligible for other coverage or benefits?	☐ NO (skip to PART IV)	☐ YES

If YES, please provide, type of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Others:_____

NAME OF POLICY HOLDER	First Last
POLICY HOLDER EMPLOYER INFORMATION	Name of policy holder Employer
POLICY INFORMATION	Name of insurance group or plan number
	Policy Account Number / Phone Number of insurance group or plan ( ) -

PART IV : CLAIM INFORMATION

This claim is being submitted for:	☐ PERIODIC SUBMISSION every calendar year (skip to PART V)	☐ NEW NON-WORK RELATED INJURY OR ILLNESS (complete the following)	☐ NEW WORK RELATED INJURY OR ILLNESS (complete the following)
DESCRIPTION of Injury or Illness			
HOW it occurred. Describe sequence of events and provide a complete description of Injury. (include information of other parties involved)	Attach additional pages if necessary.		
WHERE (address of location)			
WHEN (date & time)			

PART V : AUTHORIZATION

I/We hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We hereby authorize the attending physician or any hospital to furnish and disclose to the Southern California Pipe Trades Health & Welfare Fund or its agents all records and information concerning my physical condition that are within their possession or knowledge. I/We further authorize the Health & Welfare Fund to use or disclose the information contained in its claim files in whatever way deemed necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this claim. I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Southern California Pipe Trades Health & Welfare Fund with information regarding benefits to which I/we may be entitled.

X	
Participant's Signature	Date
X	
Patient's Signature (Not required if under 18 years of age)	Date