

**MEDICAL CLAIM FORM**  
**OTHER INSURANCE / POSSIBLE ACCIDENT / ILLNESS**  
**INFORMATION REQUEST**  
**Toledo Electrical Welfare Fund**

**P.O. Box 60408**  
**Rossford, Ohio 43460**

**Telephone: 419/666-4450**  
**Fax: 419/666-5410**

Avoid Processing delays by filling out and returning as soon as possible. Please print and answer questions. The Accident / Injury / Illness may involve other liability such as auto insurance, workers' comp., or coverage under another program, such as insurance through your spouse.

**SECTION 1 - PARTICIPANT INFORMATION**

Name of Insured \_\_\_\_\_ Last 4 Digits of Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ Telephone Number with area code \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status Married  Divorced  Sex Male   
Single  Legal Separation  Female   
Widowed

**SECTION 2 - PATIENT INFORMATION (If Different than Participant in Section 1)**

Name of Patient \_\_\_\_\_ Relationship to Insured ( Self, Spouse, Child) \_\_\_\_\_

**SECTION 3 - ILLNESS OR ACCIDENT (THIS SECTION MUST BE COMPLETED)**

**If Illness:** Describe Illness: \_\_\_\_\_  
Date Symptoms began: \_\_\_\_\_ Time: \_\_\_\_\_ AM or PM  
Job Related: No  Yes

**If Accident:** What happened? \_\_\_\_\_  
Where did it happen? \_\_\_\_\_  
Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ AM or PM  
Job Related No  Yes

**SECTION 4 - OTHER INSURANCE INFORMATION** Is the Patient covered by other health insurance? No  Yes   
If Yes, please complete this section.

Name of Insured \_\_\_\_\_ Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Employer telephone (including area code) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Group Number and/or Contract Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City, State and Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_

**I realize that failure to disclose other insurance coverage information or to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the benefit plans.**

Signature \_\_\_\_\_ Date \_\_\_\_\_