OTHER INSURANCE / POSSIBLE ACCIDENT / ILLNESS

INFORMATION REQUEST

Toledo Electrical Welfare Fund
P.O. Box 60408
Rossford, OH 43460

Office: 419.666.4450
Fax: 419.666.5410
www.electricalfunds.org

Avoid delays in processing by filling out this form and returning to the Benefits Office as soon as possible. Please print and answer all questions. The Accident , Injury and/or Illness may involve other liability such as auto insurance, workers' compensation or coverage under another program; such as insurance through your spouse.

SECTION 1—PARTICIPANT INFORMATION

Name of Insured | Last Four of SSN or UID

Street Address | Phone Number with area code

City | State | Zip Code | Date of Birth

Marital Status: Married ☐ Divorced ☐ Legal Separation ☐ Single ☐ Widowed ☐

Sex: Male ☐ Female ☐

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 Symptom Began:

Time (AM or PM):

Job Related (Yes or No):

If Accident: What happened? | Date of Accident:

Time (AM or PM):

Where did it happen? | Job Related (Yes or No):

SECTION 4—OTHER INSURANCE INFORMATION

Name of Insured | Date of Birth | Last Four of SSN

Insurance Company Name | Group #/ Contract # | Insurance Effective Date

Insurance Company Address | City, State and Zip Code | Phone 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 of Insured in Section 1 | Date