2017 ANNUAL CLAIM FORM

SHEET METAL | AIR | RAIL | TRANSPORTATION

SMART

SHEET METAL WORKERS | LOCAL UNION NO. 36

Arkansas SMART Local 36 Welfare Fund
2319 Chouteau Ave., Ste. 300
St. Louis, MO 63103
Phone: 314-652-8175
Fax: 314-652-9356
email: cfoster@sheetmetal36.org

Participant's Name: _____ Participant's Social Security No: _____

Address: _____ Birthdate: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Email: _____ Cell Phone: _____

Employer' Name: _____ Phone: _____

Are you retired and eligible for Medicare benefits? Member YES NO Spouse YES NO

If yes, please provide effective date for Medicare coverage for yourself and/or your spouse.

Member Medicare Number: _____ Spouse Medicare Number: _____

Member Medicare PART A Effective: ___/___/_____ Spouse Medicare PART A Effective: ___/___/_____

Member Medicare PART B Effective: ___/___/_____ Spouse Medicare PART B Effective: ___/___/_____

Dependents Covered Under SMW Local 36 Benefit Fund (Please enter names exactly as their appear on their Social Security card)

NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY	OTHER COVERAGE	
	Self/Member			YES	NO
	Spouse			YES	NO
				YES	NO
				YES	NO
				YES	NO
				YES	NO
				YES	NO

PLEASE COMPLETE QUESTIONS ON REVERSE FOR ADULT CHILDREN AGES 19-26 YRS

If you're divorced, with whom do the above dependents live? _____

Are you or any of the above dependents covered under any other plan? YES NO

If so, please complete other insurance information requested below.
This would include other insurance through yourself, spouse, or step-parents (for dependent children).

Type of Coverage: (check any that apply) Medical _____ Dental _____ Rx _____

Name of Plan: _____ Effective Date: _____

Name of Subscriber: _____ Relationship: _____

Phone Number: _____ Termination Date: _____

List dependents covered under this plan: _____

Type of Coverage: (check any that apply) Medical _____ Dental _____ Rx _____

Name of Plan: _____ Effective Date: _____

Name of Subscriber: _____ Relationship: _____

Phone Number: _____ Termination Date: _____

List dependents covered under this plan: _____

Note: If you haven't already submitted your divorce decree or court order please do so. This must be on file in order to determine benefit eligibility.
Birth certificate and marriage certificate will be required for any NEW enrollment.

I understand that the SMART Local 36 Welfare Fund may receive information from any source and may use my personal health information and that of my eligible dependents for treatment purposes, for payment purposes, for it's health care operations, and for other reasons permitted under the Health Insurance Portability and Accountability Act without specific authorization from me.

PARTICIPANT SIGNATURE: _____ DATE: _____

PLEASE COMPLETE REGARDING ADULT DEPENDENTS:

CHILDREN AGES 19-26 YRS (REGARDLESS OF FULL TIME STUDENT STATUS)

Adult Dependent Children's Information

Last Name:	First Name:	Middle Int:
Home Address:	City:	State:
Zip Code: / Home Phone:	Cell phone:	
Are you currently employed?: **YES** **NO**	Are you currently married?: **YES** **NO**	
Do you have other insurance coverage available through your own employer or your spouse's employer?: **YES** **NO**		
Have you elected this coverage?: **YES** **NO**		
Type of Coverage: Medical _____ Dental _____ RX _____ Name of Plan: _____ Effective Date: Name of Subscriber:_____ Relationship: Phone Number: _____ Termination Date: _____		

Last Name:	First Name:	Middle Int:
Home Address:	City:	State:
Zip Code: / Home Phone:	Cell phone:	
Are you currently employed?: **YES** **NO**	Are you currently married?: **YES** **NO**	
Do you have other insurance coverage available through your own employer or your spouse's employer?: **YES** **NO**		
Have you elected this coverage?: **YES** **NO**		
Type of Coverage: Medical _____ Dental _____ RX _____ Name of Plan: _____ Effective Date: Name of Subscriber:_____ Relationship: Phone Number: _____ Termination Date: _____		

PLEASE SUBMIT COPIES OF INSURANCE CARDS.

If dependent child or their spouse is employed, you MUST provide a letter from his/her current employer stating that either (A.) health insurance is available to him/her through their own active employment or (B.) health insurance is not available to him/her through your own active employment. This letter must be on company letterhead. This information must be available upon request in the future as it will be subject to periodic audit.