



LOCAL 36 BENEFIT FUNDS

2319 CHOUTEAU AVE., SUITE 300 · ST. LOUIS, MO 63103 · www.smw36benefits.org
Tel: (314) 652-8175 Toll-Free: (800) 741-9411 Fax: (314) 652-0338

November 10, 2016

Dear Member,

Enclosed please find the 2017 Annual Claim Form and the SMART Local 36 Welfare Fund Summary of Benefits and Coverage.

The 2017 Annual Claim Form is used by the Fund Office in order to maintain accurate information for you and any dependents covered under this Plan. When completing the form, the name listed for each dependent must be exactly what is printed on their social security card. For your convenience, you may also complete this form online at www.smw36benefits.org. When using the online option, you will find your information to be pre-populated and you will only need to verify accuracy and make any appropriate changes before submitting your claim form.

Please keep in mind if the Annual Claim Form is not returned to our office by February 28, 2017, claims incurred by you or your family members may be denied. You can call the Fund Office at 314-652-8175 with any questions or concerns you may have regarding the enclosed Annual Claim Form or Summary of Benefits and Coverage.

Respectfully,

SMART Local 36
Fund Office Staff

2017 ANNUAL CLAIM FORM



Return this form by mail, fax or email:
SMART Local 36 Welfare Fund
 2319 Chouteau Ave., Ste. 300
 St. Louis, MO 63103
 Phone: 314-652-8175
 Fax: 314-652-9356
 email: cfooster@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.