



INTERNATIONAL
BROTHERHOOD OF
ELECTRICALWORKERS LOCAL
NO. 150 WELFARE FUND



Send all bills to:

Blue Cross/Blue Shield
P. O. Box 1364
Chicago, IL 60601

SUPPLEMENTAL CLAIM TRANSMITTAL

GROUP NAME IBEW Local 150 GROUP # P15896

PARTICIPANT NAME _____ ID # IEL _____

IF CLAIM IS FOR A DEPENDENT, GIVE FULL NAME AND RELATIONSHIP _____

ADDITIONAL CLAIM INFORMATION ATTACHED: BILLS CORRESPONDENCE OTHER

REMARKS: _____

CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION-I certify that the foregoing statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse the Welfare Fund to the extent of the amounts paid on this claim in the event benefits are paid under any Workers' Compensation law, similar legislation, and/or any settlement for items related to this claim. I hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, physician, clinic, pharmacy or any other organization to release all information to PBA with respect to me or any of my dependents which may have a bearing on the benefits payable under the Welfare Fund or any other plan providing benefits or services. A photocopy of this authorization will be considered as effective and valid as the original and will be valid for one year from the date below

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the provider.

SIGNED _____ DATE _____
(Participant Name)