

YEARLY MEDICAL CLAIM FORM
ST. LOUIS GRAPHIC ARTS JOINT HEALTH & WELFARE FUND

THIS FORM MUST BE COMPLETED IN FULL BY PARTICIPANTS AND RETURNED TO

J. W. TERRILL BENEFIT ADMINISTRATORS
P. O. BOX 6877, CHESTERFIELD, MO 63006
(314) 594-2755 OR TOL FREE 1-800-467-5982

Participant's Last Name _____ M.I. _____ Participant's Social Security # _____ Date of Birth _____ Sex M F

Home Street Address _____ Home Phone # _____

City _____ State _____ Zip _____ Employer Name _____

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH DEPENDENT COVERED BY THIS PLAN

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	DATE OF BIRTH	SEX	ENROLLED IN MEDICARE?	ENROLLED IN OTHER GROUP COVERAGE? **	ADDRESS IF DIFFERENT FROM EMPLOYEE'S
				SPOUSE			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				CHILD			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	

** If you answered yes to enrolled in other Group Coverage, please complete the following section in full

Other Group Coverage Carrier	Effective Date	Subscriber Name	Policy Number	Indicate Person Or Persons Covered

IF DIVORCED, WHOM DO THE CHILDREN LIVE WITH? _____ IF YES, PLEASE STATE THE FULL NAME OF THE PERSON WHO HAS MEDICAL RESPONSIBILITY ORDERED BY THE COURTS _____ IF YES, PLEASE SEND A COPY OF THE DIVORCE DECREE.

BENEFITS ARE AUTOMATICALLY ASSIGNED UNLESS THERE IS PROOF FILED THAT THE BILL HAS BEEN PAID IN FULL. TO PREDETERMINE MEDICAL NECESSITY, CONTACT HEALTHLINK, INC. THIS FORM SHOULD NOT BE USED FOR PRESCRIBING DRUG CLAIMS.

PARTICIPANT AND SPOUSE PLEASE SIGN BELOW

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSIFICATION OR WITHHOLDING OF MATERIAL FACTS MAY RESULT IN LOSS OF BENEFITS AND OTHER SERIOUS CONSEQUENCES.

FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR BENEFITS AND CLAIM PROCESSING, I HEREBY AUTHORIZE THIS TRUST FUND AND ITS AGENTS TO RECEIVE FROM AND PROVIDE TO MEDICAL PRACTITIONERS, MEDICAL-RELATED FACILITIES, INSURANCE COMPANIES, OTHER HEALTH PLANS AND OTHER PARTIES INVOLVED IN CLAIMS PROCESSING INFORMATION AS TO ANY PHYSICAL OR MENTAL CONDITION OF MYSELF OR MY COVERED DEPENDENTS. I AGREE THAT THE FUND MAY OBTAIN AN EMPLOYEE CREDIT REPORT. I KNOW THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY IS AS VALID AS THE ORIGINAL.

PARTICIPANT'S SIGNATURE _____ SPOUSE'S SIGNATURE _____ DATE _____

IT IS THE RESPONSIBILITY OF THE PARTICIPANT TO NOTIFY J.W. TERRILL BENEFIT ADMINISTRATORS IF CHARGES ARE INCURRED ANY TIME DURING THE YEAR DUE TO A WORKERS COMPENSATION CLAIM OR OTHER TYPE ACCIDENT.