MANDATORY SECOND OPINION CLAIM FORM

WELFARE PLAN – UNITED FOOD AND COMMERCIAL WORKERS LOCAL 464A
245 PATERSON AVENUE, LITTLE FALLS, N.J. 07424
Phone (973) 256-5803

THIS FORM MUST BE COMPLETED
PRIOR TO ANY ELECTIVE SURGERY

***PLEASE NOTE* – Claims for services rendered by a podiatrist for surgery will not be paid unless the second opinion is obtained by an orthopedic surgeon.**

IMPORTANT – ALL QUESTIONS ON THIS FORM MUST BE ANSWERED

THIS PART TO BE COMPLETED BY MEMBER

1. Name of Member (Please Print) _____ Age____ Soc. Sec. # _____
2. Address _____
3. Claim is made for __ self, ___ spouse, __ child – name _____ age_____
4. Nature of sickness or injury _____
5. Name of doctor who gave first opinion _____
6. Doctors address _____
7. Are you or your spouse or any of your dependents insured under any other Group, Franchise, Blues Coross, Blue Shield, or other service or prepayment plan (other than this plan)? ___ yes ___ no

   If "yes give the name and address of insuring organization:

   _____

   Do you have any source that you can pursue (other than this plan) for payment of your Medical, Surgical or Hospital bills including but not limited to any claim by reason of accident? ___ yes ___ no

   If so, state the nature of the claim _____

   State the name of the attorney representing you, if any, and his address _____

   _____
8. Is your spouse employed? ___ yes ___ no If Yes, where? _____
9. State whether or not you or anyone on your behalf has made any claim to anyone either an insurance company or otherwise for payment of your Medical, Surgical and/or Hospital bills.

I hereby certify that the statements hereon and attached are to the best of my belief accurate and I agree to reimburse local 464A Welfare Plan all monies received by me in the event I receive any monies by way of Workmen's Compensation Insurance or from any other source for this claim.
It is specifically understood that the statements made by me on this application are for the purpose of the Welfare Fund relying thereon in making payments t me and on my behalf and all costs, expenses and counsel fees that may be incurred for the collection of the same. Further, I understand and agree that I and any dependents will be disqualified from all future benefits for a period of nine months. It is specifically understood that the determination of a false claim shall be made by the trustees and their decision is final and binding.

MEMBER'S SIGNATURE _____ DATE _____

REVERSE SIDE TO BE COMPLETED BY PHYSICIAN