UBC HealthCare TRUST FUND

PLEASE SUBMIT YOUR COMPLETED CLAIM FORM TO:
UBC Healthcare Trust Fund
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone: 800-831-4914
Fax: (615) 859-4699

STATEMENT OF CLAIM

TO BE COMPLETED FOR ALL CLAIMS:

1. Employee Name_____ Soc. Sec. Number_____ Date of Birth_____

   Address_____

   _____

2. Claim is made for: Self
   (Check One) Dependent_____
   Dependent Name Relationship

   _____ Single Married
   Date of Birth Sex

3. Is this claim work-related? Yes No If "Yes," explain:_____

   _____

4. Is claim due to an illness, or accident?
   - If accident is involved: Date of accident_____ Location of Accident_____

     _____

     Describe accident in detail_____

     _____

   - If illness is involved: Nature of illness_____

     Date symptoms first appeared_____

5. Are you, your spouse or children covered by any other plan of insurance which covers this claim? Yes No
   If yes, complete the section below.

TO BE COMPLETED ONLY IF CLAIMANT HAS OTHER COVERAGE:
(Complete only if claimant has other insurance through an employer or a government program.)

Name of covered individual_____ Date of birth_____

Relationship to employee_____ Covered individual's employer_____

Soc. Sec. No._____ Group No._____ Contract No._____

Name and address of insurance company_____

_____

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the UBC Healthcare Trust Fund with full information regarding treatment rendered (including copies of records). I/We also authorize any Union Trust Fund, Association, Employer, Doctor, Hospital or Insurance Carrier to furnish the UBC Healthcare Trust Fund with information regarding benefits to which I/We may be entitled. A photostatic copy hereof shall be as valid as the original.

Employee's Signature_____ Date_____
If claim is on spouse, spouse must also sign:

Spouse's Signature_____ Date_____