NORTHERN ILLINOIS BENEFIT FUND
1295 Butterfield Road, Aurora, IL 60504-8879
Phone:(630) 978-4600 Fax-(630) 978-4616
On the web: www.nibf501.org

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result form such acts.

STATEMENT FOR MEDICAL CLAIM

At least one claim form must be completed for each person per calendar year or for any accident.

Member's Name _____ S.S. # ***or*** Insurance ID # _____

Street Address _____ Phone # _____

City & State _____ Zip _____ Claim # _____

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Relationship _____

Is the patient covered under another insurance plan? YES ☐ NO ☐

If yes, Name of other Carrier _____

Address _____

Name of Company providing coverage _____

Insured's Name _____ Policy # _____

Insured's Date of Birth _____ Insured's S.S. # _____

If claim is for other than employee:

a) Is the patient employed? YES ☐ NO ☐

Name and Address of Employer _____

_____

b) Does the patient live with the employee? YES ☐ NO ☐

c) Is the patient a student? YES ☐ NO ☐ If yes, which applies? Full Time ☐ Part-Time ☐

Name and Address of School _____

_____

COMPLETE FOR ALL CLAIMS AND COMPLETE FOR ACCIDENTAL INJURY

Reason for visit _____ **OR** Annual Physical Exam ☐

Date symptoms first appeared _____ Date of first treatment _____

Is this work related? YES ☐ NO ☐

Date of accident or injury _____ Where did accident happen? _____

How did the accident happen? _____

Was the patient at work? YES ☐ NO ☐

MEMBER'S LOSS OF TIME

Please request a separate Loss of Time form.
You **must notify by phone the date** you return to work.

OPTIONAL REQUEST

☐ Participant or Beneficiary Request for Confidential Communication Form.

☐ Request for Restrictions on Use and/or Disclosure of Protected Health Information Form.

FAILURE TO FULLY COMPLETE ALL OF THE ABOVE INFORMATION COULD RESULT IN AVOIDABLE DELAYS IN YOUR REIMBURSEMENT.

MEMBER'S SIGNATURE REQUIRED - PLEASE READ

I/We hereby certify the above statements are true and complete to the best of my knowledge. I/We authorize release, when requested by or of this fund, its representatives , all Doctors, Hospitals, or other institutions, any facts concerning the injury, illness, treatment or benefits paid to or on behalf of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Date (Patient's Signature) (Member's Signature)