MICHIGAN CARPENTERS' HEALTH CARE FUND

6525 Centurion Drive/ Lansing, MI 48917-9275
Toll free 1-800-273-5739 · Telephone (Area Code 517) 321-7502

FLEX BENEFIT CLAIM FORM

(All other claims should be submitted directly to Blue Cross Blue Shield of Michigan)

Participant's Name____

Member ID or SS Number____

Home Address____
Street City State Zip Code

Local Union #________ Telephone #___________________ Date of Birth_________________________

Enclosed claims are for (check only one) Self Spouse Son Daughter

Dependent's Name____ Date of Birth_________________

Is dependent covered by another health insurance plan? Yes No

If Yes, Name of Plan____

(ALL CLAIMS MUST BE SUBMITTED WITH ITEMIZED BILLS OR RECRIPTS)

Are claims related to an illness? Yes No If "Yes" describe____________________________

____

Are claims related to an injury/accident? Yes No If "Yes" describe_____________________

____

Is claim the result of a vehicular related accident?
Yes No If "Yes" file claim with automobile carrier.

Is claim the result of any employment?
Yes No If "Yes" file claim with workers' compensation carrier.

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information the claim involved may be denied. (If claim is for spouse, spouse must also sign.)

_________________________________ __________ ___________________________________
Spouse's Signature Date Participant's Signature

USE ONE CLAIM FORM FOR EACH FAMILY MEMBER

Benefits are not assignable to the Provider of Services