CENTRAL STATES SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND
NOTICE OF CLAIM

FROM: LOCAL NO. ______________ DATE ______________________

In order to report a claim for DEATH, ACCIDENTAL DEATH, DISMEMBERMENT, TOTAL & PERMANENT DISABILITY WAIVER OF PREMIUM, please complete this form in detail and follow the instructions set forth below.

(Please type or print)

1	Member's Name (Last) (First) (MI) Date of Birth	Social Security Number
	Member's Address (No. Street, City, State, Zip Code) Member's Phone	Occupation

2	Name and Address of Employer	Date Last Worked

3	Was Member on Medicare? ☐ Yes ☐ No If yes, send us a copy of your Medicare card

4	Type of Claim (Check One)	☐ Member Death ☐ Member Accidental Death ☐ Dependent Spouse Death ☐ Dependent Child Death	☐ Member Accidental Dismemberment ☐ Member Total & Permanent Disability (under age 50) ☐ Member Total & Permanent Disability (ages 50 thru 59)

5	Name and Address of Applicant of Benefits: (If more than one applicant, use back of form)	Telephone No. ______________ Relationship to Member: ______________
		Applicant's Social Security No.

6 Please Attach the indicated Document to this Notice of Claim	**FOR MEMBER DEATH OR ACCIDENTAL DEATH** Date of Death ______________	Member had Waiver of Premium: Claim No. ______________ Member was on TPD Claim No: ______________
	FOR MEMBER ACCIDENTAL DISMEMBERMENT	☐ Dismemberment Application Form ☐ Date Member Became Dismembered ______________
ALL DEATH CLAIMS MUST HAVE <u>CERTIFIED</u> DEATH CERTIFICATE	**FOR DEPENDENT SPOUSE OR CHILD DEATH** Name ______________	☐ Date of Death ______________ ☐ Certified Copy of Birth Certificate Relationship to Member: ______________
* form is available from Central States by calling 1(800) 323-5000	**FOR MEMBER TOTAL & PERMANENT DISABILITY** Date of Disability ______________	☐ Claimant's Statement form #1 * ☐ Claimant's Statement form #2 * ☐ Claimant's Statement form #3* ☐ Copy of Social Security Award ☐ Certified Copy of Birth Certificate ☐ Completed and Signed Health & Welfare Beneficiary Card

7	Name and Address of Local Union ______________________________________ ______________ Signature of Local Union Official ______________ Signature of Applicant

Mail this completed Notice of Claim, with the Documents requested in item 6 above, to Central States Southeast and Southwest Areas Health and Welfare Fund Life Insurance Department P.O. Box 5118 Des Plaines, IL 60017-5118	**FOR CENTRAL STATES OFFICE USE ONLY**