

# 2021 ANNUAL CLAIM FORM



Return this form by mail, fax or email:  
**SMART Local 36**  
**Health and Welfare Fund**  
**2319 Chouteau Ave., Ste. 300**  
**St. Louis, MO 63103**  
**Phone: 314-652-8175**  
**Fax: 314-652-9356**  
**email: jham@sheetmetal36.org**

Participant's Name: \_\_\_\_\_ Participant's Social Security No: \_\_\_\_\_  
 Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Are you retired and eligible for Medicare benefits? Yourself YES NO Spouse YES NO**  
 If yes, please provide effective date for Medicare coverage for yourself and/or your spouse.  
 Member Medicare Number: \_\_\_\_\_ Spouse Medicare Number: \_\_\_\_\_  
 Member Medicare PART A Effective: \_\_\_/\_\_\_/\_\_\_ Spouse Medicare PART A Effective: \_\_\_/\_\_\_/\_\_\_  
 Member Medicare PART B Effective: \_\_\_/\_\_\_/\_\_\_ Spouse Medicare PART B Effective: \_\_\_/\_\_\_/\_\_\_

## Dependents Covered Under SMW Local 36 Benefit Fund

NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY	OTHER COVERAGE	
	Self/Member			YES	NO
	Spouse			YES	NO
				YES	NO
				YES	NO
				YES	NO
				YES	NO

### PLEASE COMPLETE QUESTIONS ON REVERSE FOR ADULT CHILDREN AGES 19-26 YRS

If you're divorced, with whom do the above dependents live? \_\_\_\_\_

### Are you or any of the above dependents covered under any other plan? YES NO

If so, please complete other insurance information requested below.

This would include other insurance through yourself, spouse, or step-parents (for dependent children).

Type of Coverage: (check all that apply) Medical \_\_\_\_\_ Dental \_\_\_\_\_  
 Rx \_\_\_\_\_ Vision \_\_\_\_\_  
 Name of Plan: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Name of Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Termination Date: \_\_\_\_\_  
 List dependents covered under this plan: \_\_\_\_\_

Type of Coverage: (check any that apply) Medical \_\_\_\_\_ Dental \_\_\_\_\_ Rx \_\_\_\_\_  
 Name of Plan: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Name of Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Termination Date: \_\_\_\_\_  
 List dependents covered under this plan: \_\_\_\_\_

**Note: if you haven't already submitted your divorce decree or court order please do so. This must be on file in order to determine benefit eligibility.**

**Birth certificate and marriage certificate will be required for any NEW enrollment.**

*I understand that the SMART LOCAL 36 Health and Welfare Fund may receive information from any source and may use my personal health information and that of my eligible dependents for treatment purposes, for payment purposes, for its health care operations and for other reasons permitted under the Health Insurance Portability and Accountability Act, without specific authorization from me.*

PARTICIPANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE COMPLETE REGARDING ADULT DEPENDENTS:**  
CHILDREN AGES 19-26 YRS (REGARDLESS OF FULL TIME STUDENT STATUS)

**Adult Dependent Child's Information**

Last Name:		First Name:	Middle Int:
Home Address:		City:	State:
Zip Code:	Home Phone:	Cell phone:	
Are you currently employed?: <b>YES NO</b>		Are you currently married?: <b>YES NO</b>	
Do you have other insurance coverage <b>available</b> through your own employer or your spouse's employer?: <b>YES NO</b>			
Have you elected this coverage?: <b>YES NO</b>			

Type of Coverage:      Medical \_\_\_\_\_ Dental \_\_\_\_\_ Rx \_\_\_\_\_  
 Name of Plan: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Name of Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Termination Date: \_\_\_\_\_

**Adult Dependent Child's Information**

Last Name:		First Name:	Middle Int:
Home Address:		City:	State:
Zip Code:	Home Phone:	Cell phone:	
Are you currently employed?: <b>YES NO</b>		Are you currently married?: <b>YES NO</b>	
Do you have other insurance coverage <b>available</b> through your own employer or your spouse's employer?: <b>YES NO</b>			
Have you elected this coverage?: <b>YES NO</b>			

Type of Coverage:      Medical \_\_\_\_\_ Dental \_\_\_\_\_ Rx \_\_\_\_\_  
 Name of Plan: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Name of Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Termination Date: \_\_\_\_\_

**Please submit copies of other insurance cards if applicable.**