

RETURN THIS FORM TO:

BAY AREA AUTOMOTIVE GROUP WELFARE FUND
4160 DUBLIN BLVD., SUITE 400
DUBLIN, CA 94568-7756

TO BE COMPLETED BY EMPLOYER

Name of Employee

- NO YES
[ ] [ ] WAS THE EMPLOYEE COVERED UNDER THIS PLAN ON DATE OF DISABILITY?
[ ] [ ] WAS THE DISABILITY DUE TO OCCUPATIONAL CAUSE OR CAUSES?
[ ] [ ] IS THE CONTRIBUTION PAID?
[ ] [ ] HAS A CLAIM BEEN FILED FOR WORKER'S COMPENSATION?
[ ] [ ] WILL A CLAIM BE FILED FOR WORKER'S COMPENSATION?

Date employed

Occupation and employment status on date of disability { [ ] FULL TIME [ ] PART TIME

\$ Basic earnings per week, month, etc.

First full day unable to work date

- { [ ] TERMINATED [ ] RESUMED [ ] EXPECTED TO RESUME

Name of employer

Address

City-State-Zip Code

Telephone number

Signed

Title

Date

TO BE COMPLETED BY EMPLOYEE

Please print last name First Middle

- [ ] Male [ ] Female

- NO YES
[ ] [ ] IS THIS DISABILITY DUE TO OCCUPATIONAL CAUSE OR CAUSES?
[ ] [ ] HAS A CLAIM BEEN FILED FOR WORKER'S COMPENSATION?
[ ] [ ] WILL SUCH A CLAIM BE FILED?

Home address

City-State-Zip Code

Home phone number

Date of birth

Social Security Number

Name of employer (firm name)

Occupation

Local Union Number

First date you were unable to work at time (am-pm) Employer's Phone #

DESCRIBE DISABILITY:

WE NEED THIS SECTION COMPLETED IN ORDER TO FURTHER CONSIDER YOUR CLAIM.

All answers are true and correct to the best of my knowledge.

Employee's signature

Date signed

COMPLETE ONLY IF ACCIDENT INVOLVED

Date of accident Time (am-pm) Where did accident occur?

DESCRIBE THE ACCIDENT FULLY:

THE ATTENDING PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM

PLEASE ALSO SIGN THE AUTHORIZATION TO RELEASE INFORMATION ON REVERSE SIDE OF FORM.

**PART A**

**TO BE COMPLETED BY PATIENT (MEMBER)**

**AUTHORIZATION FOR RELEASE OF INFORMATION  
GROUP HEALTH BENEFITS**

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policy holder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Bay Area Automotive Group Welfare Fund (hereinafter called The Fund) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by The Fund or its authorized claims paying administrator to determine eligibility for benefits or services under a policy. Any information obtained will not be released by The Fund to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., employer, group policyholder, contract holder, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of the Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and one-half years from the date shown.

PATIENT'S SIGNATURE (if other than a minor child)  X	MEMBER'S SIGNATURE  X	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (Member or Authorized Person) X
	DATE	

**PART B**

**ATTENDING PHYSICIAN'S STATEMENT**

1. DIAGNOSIS AND CONCURRENT CONDITIONS (If diagnosis code other than ICD9* used, give name.)			
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S  EDC	EMPLOYMENT? No <input type="checkbox"/> Yes <input type="checkbox"/>	PREGNANCY? No <input type="checkbox"/> Yes <input type="checkbox"/>	
3. DATES OF SERVICES (If previous form submitted to this carrier, you need show only dates since last report.)			
4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? (If yes, state when and describe.) No <input type="checkbox"/> Yes <input type="checkbox"/>	7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? No <input type="checkbox"/> Yes <input type="checkbox"/>		
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work)  FROM _____ THRU _____	9. PATIENT WAS PARTIALLY DISABLED  FROM _____ THRU _____		
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.	11. PATIENT WAS HOUSE CONFINED  FROM _____ THRU _____		
12. HOSPITALIZATION DATES  ADMITTED _____ DISCHARGED _____	13. DOES PATIENT HAVE OTHER HEALTH COVERAGE? (If yes, identify.) No <input type="checkbox"/> Yes <input type="checkbox"/>		
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE TELEPHONE
STREET ADDRESS		CITY	STATE ZIP CODE

\*ICD9—International Classification of Diseases

INDIVIDUAL PRACTITIONERS S.S. NO (Must be furnished under authority of law.) \_\_\_\_\_

ALL OTHERS—EMPLOYER I. D. NO. \_\_\_\_\_