Southern California Dairy Industry
Security Trust Fund
1200 Wilshire Blvd. 5th Floor
Los Angeles, CA. 90017
Phone No. (866) 481-5841 • (562) 463-5033
Fax No. (562) 463-5894

CLAIM FORM MUST BE SUBMITTED WITHIN 90 DAYS OF SERVICE

ANSWER ALL QUESTIONS THAT APPLY • SIGN WHERE INDICATED

EMPLOYEE DATA

Employee Name	Social Security Number	☐ Male ☐ Female	Date of Birth
Complete Home Address			☐ Married ☐ Widowed ☐ Single ☐ Divorced
City	State	Zip	Telephone Number
Employed By	Local Union No.		

PATIENT DATA

Claim is made for ☐ Self ☐ Spouse ☐ Child	First and Last Name of Claimant	☐ Male ☐ Female	Date of Birth	Social Security Number of Claimant

GIVE THE FOLLOWING INFORMATION ABOUT YOUR SPOUSE. (MUST BE COMPLETED IN ALL CASES)

Spouse Name _____ Social Security No. _____ Date of Birth _____

Employer Name _____ Employer Address _____

OTHER INSURANCE DATA

Do you, your spouse, or child have any other Group Insurance (other than the Trust Fund)? ☐ Yes ☐ No
If yes, give name and address of insurance company or organization providing benefits for ☐ Self ☐ Spouse ☐ Child

Insured Name	Name and address of insurance company or organization providing benefits or service	Policy No. or Identification No.

ACCIDENT DATA

WAS INJURY CAUSED BY AN ACCIDENT? ☐ YES ☐ NO IF "YES", THIS PORTION MUST BE COMPLETED

Date of Accident	Was claimant at work ☐ Yes When accident happened ☐ No	Date Last Worked _____ Date Returned to Work _____	Were you places on disability due to this condition? ☐ Yes ☐ No

Place and Details of Accident

I/We jointly certify that the above information is true and correct. I/We hereby authorize all providers of medical care to furnish the Southern California Dairy Industry Security Trust Fund with full information regarding this including copies of their records. I/We further authorize the release of this information to any third party, if the release of the information is necessary to the review or payment of the claim; i.e. for a medical necessity review, coordination of benefits determination, etc.

Date →	Spouse's Signature →	Employee's Signature →

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payments directly to the Provider of service for all benefits, if any, otherwise payable to me for services on the attached claim but not to exceed the reasonable and customary charge for those services.

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Signed (Insured Signature) Date