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**PROOF OF EMPLOYEE'S CLAIM**

Enter your answers in the space provided. The field will expand to accommodate your answers.

1.	Employee's Name:				2.	Local Union Number:			
3.	Employee Address:								
4.	Member Number <sup>i</sup> :			4a.	Claim Number:				
4b.	UFN or UFD Number:			5.	Employer:				
6.	Dependent's Name				6a.	Relationship to Member			
6b.	Dependent's DOB								
7.	Please provide all details: (When, Where, How did the injury occur)								
7a.	Was the injury/illness incurred in the course of any employment or occupation?					No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
7b.	Was the accident/altercation brought on by another party?					No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
8.	Are any of the claimed expenses covered under any other group insurance plan or Medicare?					No	<input type="checkbox"/>	Yes*	<input type="checkbox"/>
*If your answer to Question 7 was Yes, please answer the questions below:									
8a.	Name of Employee Covered under other Group Plan:								
8b.	Relationship to Claimant:								
8c.	Name and Address of Other Employer:								
8d.	Name and Address of Employer's Group Insurance Company:								
8e.	Group Policy No. or Individual Subscriber No.								

I hereby represent that the illness or injury for which this claim is made was not incurred in the course of any employment or occupation. I further represent that I have not filed and do not intend to file a claim for Workmen's Compensation.

UNDER PENALTY OF PERJURY, I HEREBY AFFIRM AND SWEAR THAT ALL OF THE STATEMENTS CONTAINED HEREIN AND ON ANY OTHER DOCUMENTS RELATING TO THIS CLAIM, SUBMITTED HEREWITH OF THEREAFTER, ARE TRUE AND CORRECT TO MY KNOWLEDGE.

Witness to Employee Signature:	Date:	Employee Signature:

<sup>i</sup> You may provide your UFN/UFD number or your member number. If you know your claim number, providing it will speed your claim's review.