66 Grand Avenue • Englewood, New Jersey 07631-3545
• (201) 569-8801 • Fax (201) 569-1085
• www.ufcwnationalfund.org • UFCWFundSupport@ufcwnationalfund.org

PROOF OF CLAIM (EMPLOYEE OR DEPENDENT)

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

1.	Employee's Name:			2.	Local Union Number:		
3.	Employee Address:						
4.	Employee Email:						
5.	Member Number[i]:			5a.	Claim Number:		
5b.	UFN or UFD Number:			6.	Employer:		
7[ii].	Dependent's Name:			7a.	Relationship to Member:		
7b.	Dependent's DOB:						
8.	Please provide all details: (When, Where, How did the injury occur)						
8a.	Was the injury/illness incurred in the course of any employment or occupation?			No		Yes	
8b.	Was the accident/altercation brought on by another party?			No		Yes	
9.	Are any of the claimed expenses covered under any other group insurance plan or Medicare?			No		Yes*	

*If your answer to Question 9 was Yes, please answer the questions below:

9a.	Name of Person Covered under other Group Plan:	
9b.	Relationship to Claimant:	
9c.	Name and Address of Other Employer:	
9d.	Name and Address of Employer's Group Insurance Company:	
9e.	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.

Date:	Employee Signature:

[i] 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.

[ii] If this claim is for a dependent, complete section 6.