Timber Products Manufacturers Trust
951 East Third Avenue, Spokane, WA 99202

ACCIDENTAL INJURY BENEFIT CLAIM FORM

ACCIDENTAL INJURY BENEFIT

Maximum Benefit per Accident	$300.00
Deductible	Waived
Benefit Percentage	100%

Subscribers and Dependents qualify for this Benefit if they were eligible on the date of the Accident ("subscriber", "dependent" and "eligibility" as defined in the plan booklet). Expenses incurred under this Benefit are not subject to the deductible. Charges in connection with an Accidental Injury are payable at 100% of the Maximum Eligible Expense, up to the maximum benefit stated under the "Schedule of Medical Benefits." Any portion of the charges exceeding the maximum benefit will be considered under the Medical Benefits Section of the Plan, subject to all Plan conditions, exclusions and limitations. Services and supplies must be ordered by a doctor and furnished within a ninety-day period beginning with the date of the Accidental Injury.

Charges for the following are covered under this benefit when furnished for medical care to the Covered Person for Accidental Injuries, including but not limited to:

1. Services and supplies (including Room and Board) furnished by a Hospital for medical care in that Hospital.
2. Doctors' services for surgical procedures and other medical care.
3. Surgical dressings.
4. X-ray and laboratory examination.
5. Private duty professional nursing services by a Registered Nurse or a Licensed Practical Nurse.
6. Casts, splints, trusses, braces, and crutches.
7. Ambulance service for local travel to the nearest facility capable of treating the Injury.

Specifically excluded under this Benefit are costs associated with chiropractic and alternative care, as well as dental services.

Your claim must first be submitted and processed by your Primary and/or Secondary carrier. An Explanation of Benefits showing liability will be required when submitting the Claim Form.

Your claim must be submitted within twelve (12) months of the accidental injury date in order for reimbursement to be considered.

(Expenses not eligible under this benefit may be considered under the Medical Benefits of the Plan.)

951 East Third Avenue, Spokane, WA 99202 σ (509) 535-4646 (phone) σ (509) 534-6106 (fax) σ www.timberassociation.com

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EMPLOYEE INFORMATION:

Name: _____ Birthdate: _____ Subscriber ID Number: _____

Address: _____

City: _____ State: _____ Zip: _____ ☐ Check here if this is a new address

Employer Name _____ Phone: _____

PATIENT INFORMATION (IF OTHER THAN EMPLOYEE):

Name: _____ Birthdate: _____ Relationship: ☐ Spouse ☐ Child

Mailing Address (If different than above): _____

City: _____ State: _____ Zip: _____

ACCIDENTAL INJURY / THIRD PARTY LIABILITY:

Is this claim the result of an accidental injury for which another party may be responsible: ☐ Yes ☐ No

If NO, please provide an explanation for the injury(s) sustained below.

If YES, you will need to complete and return the full accident questionnaire. This questionnaire will be mailed to you and is also available online at https://www.timberassociation.com/tpm-trust-forms/.

If this is a work related injury, please file your claim with your employer's workers' compensation carrier.

EXPLANATION OF INJURY:

Include date of injury, part of body injured, where injury occurred.

PAYMENT AND DOCUMENTATION INFORMATION:

A copy of Primary and/or Secondary Explanation of Benefits is required for payment of the Accidental Injury Benefit.
Failure to complete this form and provide the necessary documentation could delay the processing and payment of your claim.

Signature:	Date:

Submit form with supporting documentation to: enrollments@tpmrs.com or (509) 534-6106 (fax)