PIBF

INSURED'S NAME AND ID NUMBER:

____

PLEASE LIST ALL MEDICAL CONDITIONS FOR WHICH THE PATIENT RECEIVED TREATMENT. IT IS ONLY NECESSARY TO LIST THE CONDITIONS THAT WERE TREATED DURING THE MONTHS IN QUESTION PRIOR TO THE ENROLLMENT DATE.

Name of Patient	Physician Name & Treatment Date	Medical Illness/ Condition

By my signature below, I authorize any and all Medical Providers contacted by the Pipeline Industry Benefit Fund to release my medical information to the Fund office.

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Signature of Patient or Legal Guardian

____

Date Signed

**PLEASE INDICATE COMPLETE NAME AND ADDRESS OF PHYSICIANS SEEN ON THE REVERSE SIDE OF THIS FORM.

4845 S. 83RD E. Ave. | Box 470950 | Tulsa, Oklahoma 74147-0950 | (918) 280-4800 | Fax (918) 280-4899 | www.pibf.org