



**ACCIDENT/ILLNESS CLAIM FORM**

YOUR PROVIDER HAS ENTERED A DIAGNOSIS CODE THAT COULD BE RELATED TO AN ACCIDENT/INJURY. EVEN IF YOUR CONDITION WAS NOT DUE TO AN ACCIDENT/INJURY, PLEASE COMPLETE AND RETURN THE ENCLOSED FORM. IF THIS WAS AN ACCIDENT, INCLUDE ANY ADDITIONAL INFORMATION REQUESTED.

**BOTH PAGES MUST BE COMPLETED AND THE FORM MUST BE SIGNED**

**SECTION A – GENERAL INFORMATION**

Fund ID:

Claim #:

Participant Name:

Patient Name:

Patient's DOB:

Status of Patient (Check One):  Participant  Spouse  Minor Dependent  Adult Dependent

**SECTION B – PART OF THE BODY INJURED OR AFFECTED (Please mark all areas involved)**

- |                                      |                                     |                                |   |  |
|--------------------------------------|-------------------------------------|--------------------------------|---|--|
| <input type="checkbox"/> Head        | <input type="checkbox"/> Face       | <input type="checkbox"/> Eye   | <input type="checkbox"/> Leg (R or L)           | <input type="checkbox"/> Shoulder (R or L) |
| <input type="checkbox"/> Ear         | <input type="checkbox"/> Nose       | <input type="checkbox"/> Mouth | <input type="checkbox"/> Knee (R or L)          | <input type="checkbox"/> Arm (R or L)      |
| <input type="checkbox"/> Tooth/Teeth |                                     |                                | <input type="checkbox"/> Ankle (R or L)         | <input type="checkbox"/> Wrist (R or L)    |
|                                      |                                     |                                | <input type="checkbox"/> Foot (R or L)          | <input type="checkbox"/> Hand (R or L)     |
| <input type="checkbox"/> Chest       | <input type="checkbox"/> Abdomen    |                                | <input type="checkbox"/> Hip (R or L)           |  |
| <input type="checkbox"/> Neck        | <input type="checkbox"/> Upper Back |                                |   |  |
| <input type="checkbox"/> Mid-Back    | <input type="checkbox"/> Lower Back |                                | <input type="checkbox"/> Other (Describe) _____ |  |

**SECTION C – ABOUT THE PATIENT'S CONDITION**

Describe your condition (When did it start? What symptoms? When treatment was sought?):

\_\_\_\_\_

Was the condition related to an Accident/Injury:  Yes  No

**If yes, please continue:**

Date of Accident/Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident/Injury: \_\_\_\_:\_\_\_\_ a.m. or p.m.

Location of the Accident/Injury:

- Your Home
- Someone else's Home – Homeowner Name: \_\_\_\_\_
- Place of Business - Business Name: \_\_\_\_\_
- Public Location (sidewalk, Park, Pool, Athletic Field, etc.)
- School (Playground, Athletic Event, School Bus, Classroom)
- Work - Employer name: \_\_\_\_\_
- Motor Vehicle Accident (Car, Truck, 4-Wheeler, Motorcycle, Snowmobile, etc.)
- Other (dog bite, fight) Describe: \_\_\_\_\_

Address where the accident/injury happened: \_\_\_\_\_

How did the accident/injury happen? \_\_\_\_\_

Witnesses? \_\_\_\_\_

Police Department Involved? \_\_\_\_\_

**If yes, please provide the official police report.**

**SECTION D – ADDITIONAL INFORMATION**

Attorney?  Yes  No

Attorney Name: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

Attorney Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Have you been offered a settlement:  Yes  No

**If yes and you have received a settlement, include a copy of the settlement agreement.**

**Other Insurance Information:**

- Auto Insurance
- Worker’s Compensation
- School
- Home Owner Insurance
- Personal Liability (place of business, etc.)
- Other

Carrier Name: \_\_\_\_\_

Policy Number/Claim Number: \_\_\_\_\_

Adjuster’s Name/Phone Number: \_\_\_\_\_

**If there is other insurance involved, please provide a breakdown of the other carrier’s payments.**

**SIGNATURE\***

The undersigned certifies that the above answers are true and correct to the best of my knowledge and belief. I understand that it constitutes fraud for me or anyone to knowingly complete this form with false or misleading information or to knowingly omit important facts. Further, I agree that if any of the above information is untrue, I agree to reimburse the Welfare Fund for any money it was induced to pay because of the information I provided. I understand I have the responsibility to inform the Welfare Fund of any changes in the above information.

\_\_\_\_\_  
Participant’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone:

**\*IF THE INJURED PARTY IS NOT THE PARTICIPANT, THEN THIS FORM MUST BE SIGNED BY THE INJURED PERSON’S LEGAL GUARDIAN AND LEGAL REPRESENTATIVE, IF APPLICABLE, OR THE PARTICIPANT’S SPOUSE OR ADULT DEPENDENT IN THE APPROPRIATE AREA BELOW.**

**LEGAL GUARDIAN/LEGAL REPRESENTATIVE\*\***

\_\_\_\_\_  
Legal Guardian’s and/or Legal Representative’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone:

**\*\* This Agreement must also be signed by the Legal Guardian/Legal Representative of the Injured Person if the Participant is not the Legal Guardian/Legal Representative of the Injured Person.**

**SPOUSE OR ADULT DEPENDENT/INJURED PERSON\*\*\***

\_\_\_\_\_  
Spouse or Adult Dependent’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone:

**\*\*\* If the Injured Person is a Spouse or Adult Dependent, then the Spouse or Adult Dependent must sign this form.**

**IMPORTANT NOTICE REGARDING THE FUND’S SUBROGATION & REIMBURSEMENT RULES**

As explained in the Fund’s Summary Plan Description (“SPD”), no benefits will be paid under any coverage of the plan with respect to any injury or sickness for which a Third Party may be liable or legally responsible. However, you may be eligible for your claims to be advanced/paid by the Fund under the hardship appeal procedures specified on pages 86-87 of the SPD. If approved under the hardship appeal procedures, then you, and your attorney, must sign the Fund’s Subrogation, Assignment of Rights and Restitution Agreement (“Subrogation Agreement”). The Subrogation Agreement includes many important terms and conditions, including the obligation to reimburse the Fund 100% of all claims paid by the Fund (without reduction for attorney’s fees and costs and without regard to whether you have been made whole). Please contact the Fund for more information regarding the hardship appeal procedures.