
ACCIDENT FORM

You will receive an accident form (orange form) when a claim is received showing an accidental injury diagnosis. Whether the accident is automobile, work or an accident in your home, the form must be completed.

You will also receive this form if you simply had an ache or pain that did not involve any type of accident.

Please complete the form to the best of your knowledge and return it promptly to expedite the processing of your claims.

EMPLOYEE INFORMATION

LAST: _____ FIRST: _____ MIDDLE: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

SS#: XXX – XX – _____ DOB: _____ SEX: _____ MARITAL STATUS: _____

PHONE NUMBER: _____ EMAIL: _____

CLAIM IS MADE FOR: SELF / DEPENDENT

DEPENDENT'S INFORMATION

LAST: _____ FIRST: _____ MIDDLE: _____

RELATIONSHIP TO EMPLOYEE: _____ DOB: _____ SEX: _____ MARITAL STATUS: _____

- DATE ACCIDENT OCCURRED: _____

- WAS CLAIMANT AT WORK WHEN THE ACCIDENT OCCURRED: YES / NO

- WAS DISABILITY CAUSED BY WORK: YES / NO

- HAS THERE BEEN OR WILL THERE BE A CLAIM FILED FOR THIS DISABILITY WITH THE WORKMAN'S COMPENSATION CARRIER: YES / NO

- NAME OF EMPLOYER: _____

PLEASE BRIEFLY DESCRIBE THE ACCIDENT: HOW DID IT HAPPEN? WHERE DID IT HAPPEN?

CERTIFICATION AND AUTHORIZATION:

I / We jointly certify that the above information is true and correct. I / We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish Plumbers, Pipe Fitters & MES Local Union 392 Health & Welfare Fund with full information regarding treatment rendered (including copies of their records). I / We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish Plumbers, Pipe Fitters & MES Local Union 392 Health & Welfare Fund with information regarding benefits to which I / we may be entitled. (If claim for spouse, spouse must also sign.) A copy or photocopy of this authorization shall be considered as effective and valid as the original.

DATE	EMPLOYEE'S SIGNATURE	SPOUSE'S SIGNATURE (if needed)
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