Print

INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free (800) 962-3158
Fax (812) 238-2553 www.IndianaLaborers.org

ACCIDENT INFORMATION FORM

Participant

Name: _____ ID#: _____

Address: _____

City, State, Zip: _____

Patient: _____

Date of Accident: _____

Condition: _____

Below are the details with regard to where, when and how the claim on the above listed patient happened:

1. Where: _____

   When: _____

   How: _____

   _____

2. Did this specific incident occur while you were working? (select one) Yes ○ No ○

3. Other than Laborers Benefits, is there other insurance (Homeowners, Workers Comp, Auto, Motorcycle or ATV) that may be responsible for this medical expense? (select one) Yes ○ No ○

4. Is there another party responsible for these claims? (select one) Yes ○ No ○
   If so, do you plan to pursue the responsible party? (select one) Yes ○ No ○
   Have you or will you hire an attorney? (select one) Yes ○ No ○

Upon receipt of this information, the claim(s) will be reviewed for consideration of benefits.

_____ _____

Injured Party Signature (or Participant, if injured party is a minor) Date

Claims Department
Laborers Welfare Fund