INDIANA LABORERS WELFARE FUND
ACCIDENT INFORMATION FORM

____
Member ID#

____
Participant Name and Address	Date of Service

Participant Email Address

____
Patient Name (if other than Participant)	Diagnosis

GENERAL INFORMATION

Describe what happened, where it took place and when it occurred:

YES NO Was this claim related to an incident?

______________________________	______________________________
Attorney Name (if applicable)	Attorney Phone Number

This claim is related to:

☐ On-site work incident or illness (Complete Sections A and D)
☐ Motorized vehicle incident, including in, on or around a vehicle, such as watercraft, ATV or automobile. (Complete Sections B and D)
☐ Other (Complete Sections C and D)

☐ YES ☐ NO Were the police called? If "YES" submit a copy of the police report.

SECTION A - Complete *only* if you checked "On-site work incident or illness" then skip to Section D

☐ Yes ☐ No Did you file a Worker's Compensation claim?	______________________
Claim Number

If "NO" state the reason why ____

____

If "YES", what is the claim status?

☐ In review
☐ Accepted Liability
☐ Denied Liability** (Please include a copy of the denial letter)
☐ Appeal Denial ** (Please include a copy of the denial letter)

SECTION B – Complete *only* if you checked "Motorized Vehicle Incident" then skip to Section D

Auto Insurance Carrier of Responsible Party ______________________ Contact Information ______________________

Policy Number ______________________ Claim Number ______________________

Additional Information

☐ YES ☐ NO Has the patient received a bodily injury settlement?

With whom did the patient settle? ☐ Patient's insurance company ☐ Another party's insurance company

SECTION C – Complete if you checked "Other" then skip to Section D

☐ YES ☐ NO Did the incident occur on property you own? (If YES, skip to Section D)

☐ YES ☐ NO Have you filed an insurance claim with the at-fault party, or do you anticipate doing so?

At Fault Party's Name ______________________

At-Fault Party's Insurance Carrier ______________________ Contact Information ______________________

Policy Number ______________________ Claim Number ______________________

SECTION D – Read and Complete

Your benefits under the Indiana Laborers Welfare Fund (The Plan) includes a subrogation provision. "Subrogation" means that if the Plan provides any benefits on your behalf for injuries caused by another party who may be liable for those injuries, The Plan may be entitled to recover those costs from any settlement you receive from the at-fault party. Your Plan benefits also excludes coverage for benefits that would be payable under any personal injury protection, MedPay, uninsured or under-insured motorist coverage or worker's compensation you may have. Therefore, the Plan will also have the right to be reimbursed for any medical benefits from the proceeds of any personal injury protection, MedPay, uninsured, under-insured motorist coverage or worker's compensation coverage applicable to this incident. Please contact the Fund Office prior to settlement.

I agree that any property/casualty, automobile or workers' compensation carrier or government agency may release any personal health information about me related to this incident to Indiana Laborers Welfare Fund. This authorization is valid during the subrogation process.

Participant Signature (if patient is a minor) ______________________ Date ______________________

Printed Name ______________________ Phone Number ______________________

Patient Signature ______________________ Date ______________________

Printed Name ______________________ Patient Phone Number ______________________