IUOE Local 132 Health and Welfare Fund
P.O. Box 2626 Huntington, West Virginia 25726-2626
(304) 525-0482 or 1-800-642-3525 www.iuoe132.org

ACCIDENT and/or INJURY CLAIM FORM

This form must be completed by the Participant. Be sure all Questions are answered. Unanswered Questions will delay benefit consideration until the information is received.

Participant Information

Name: _____ ID number or SSN: _____

Address: _____ Home Phone: _____

_____ Other Phone: _____

Name of Claimant and Relation to Participant

Name: _____ Dependent SSN: _____

Relationship: _____

Is the claimant covered by any other insurance carrier or Health Plan? ☐ Yes ☐ No If yes, compete the following

(Check all that apply)

☐ Group ☐ Single
☐ Individual ☐ Family
☐ Medicare ☐ COBRA
☐ Medicaid

Name of Insured _____
Name of Insurance _____
Policy Number _____
Insurance phone number _____
Effective date of coverage _____

Was treatment due to a Work Related Injury or Illness

Was treatment due to work related Injury or Illness? ☐ Yes ☐ No If yes, complete the remainder of this section.

Describe incident: _____

Date injury or illness occurred: _____

Did you report the incident to your employer? ☐ Yes ☐ No

Have you filed a Workers' Compensation Claim? ☐ Yes ☐ No

Name and address of Workers' Compensation Carrier _____

Was treatment due to an Accident or Injury

Was treatment due to an Accident or Injury? ☐ Yes ☐ No If yes, complete the remainder of this section.

Please provide the type of accident or injury: ☐ Auto ☐ Other

Date of the accident or injury: _____
How did the accident or injury occur: _____
Where did the accident or injury occur: _____

I hereby declare the information I have provided is true and correct. I understand that a false statement may disqualify me from benefits and that the Fund has the right to recovery from any Participant, any payments made as a result of misrepresentation, mistake or error, irrespective of the party causing such mistake or error.

I authorize release to or by the IUOE Local 132 Health and Welfare Fund of any medical or insurance information required to process any claims submitted on my behalf. A photocopy of this document may be honored.

I understand it is my responsibility to notify the Fund Office immediately should myself, my spouse and/or dependent child(ren) become eligible with another insurance carrier or Plan.

➔ _____ ➔ _____

Participant's Signature **Date Signed**