Southwest Health Benefits Fund

8441 Gulf Freeway Suite 304 · Houston, TX 77017
Phone (713) 643-9300 · 866-236-3148 · Fax (866) 316-4794

Injury Report

All questions must be completed by the Participant.
If any of the questions do not apply, please indicate so by answering with an N/A for not applicable. Please return the signed form to the address listed above or fax to 1-866-316-4794

Please complete the following questions.

Participant's name _____Phone No._____ UID or SSN _____

Patient's name _____ Date injury occurred _____

Please describe how, when and where injury occurred _____

_____

Did this injury occur as a direct result of your employment and while on the job? ☐ Yes ☐ No

If yes, return this form and file any related claims directly with your employer's worker's compensation carrier.

Please complete the following questions if the injury was the result of an automobile accident or other incident caused by a third party. No claims can be processed until all information requested below is received.

Please list name(s) of other party(ies) involved in the incident _____

Insurance company of other party _____ Phone No._____

Address_____ Claim No. _____

Were police called? ☐ Yes ☐ No Was accident report completed by police? ☐ Yes ☐ No

If a report was completed, please attach a copy to this form.

Were charges lodged against you? ☐ Yes ☐ No

Were charges lodged against the other party? ☐ Yes ☐ No

Have you hired an attorney to represent you in this matter? ☐ Yes ☐ No

If yes, attorney's name _____ Phone No. _____

Address_____

Participant's signature _____ **Date**_____