Revised 12/18/2025

INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Fax (812) 238-1563
www.indianalaborers.org

ACCIDENT INFORMATION FORM

NAME
ADDRESS
CITY/STATE/ZIP

Patient Name: _____

Date of Accident/Injury:_____

Claim Reference Number:_____

Diagnosis/Condition:_____
_____
_____

Member ID:_____

The diagnosis on the referenced claim indicates there could have been an accident or injury. Please advise where, when and how the claim on the referenced patient occurred:

1. Where: _____

When: _____

How: _____

2. Did this specific incident occur while you were working? ☐ YES ☐ NO

3. Other than Laborers Benefits, is there other insurance that may be responsible for this medical expense? (Homeowners, Workers Comp, Auto, Motorcycle or ATV) ☐ YES ☐ NO

3a. Did you file a Worker's Compensation claim? ☐ YES ☐ NO

4. Is there another party responsible for these claims? ☐ YES ☐ NO
If so, do you plan to pursue the responsible party? ☐ YES ☐ NO
Has an attorney been hired regarding this accident or injury? ☐ YES ☐ NO

_____ _____
Attorney Name (if applicable) Attorney Phone Number

Upon receipt of this information, the claim(s) will be reviewed for consideration of benefits.
Failure to complete and return this form will result in non-payment of claims.

_____ _____
Patient Signature (or Participant, if patient is a minor) Date

_____ _____
Printed Name Phone Number