



INDIANA LABORERS WELFARE FUND

P.O. Box 1587 • Terre Haute, IN 47808

Phone: (812) 238-2551 | Fax: (812) 238-1563

www.indianalaborers.org | info@indianalaborers.org

WE NEED MORE INFORMATION ABOUT YOUR CLAIM

Member: _____ Claim Number: _____
Patient: _____ Dates of Service: _____
Member ID: _____ Diagnosis/Condition: _____

Why are you receiving this form? We received a medical claim that could be related to an injury or accident.

What do you need to do?

Complete the back side of this form and return it to the Fund Office within 45 days.

Need Help? If you have questions or need help completing this form, please call the Claims Department: 812-238-2551 option 2.

FAILURE TO COMPLETE AND RETURN THIS FORM WILL RESULT IN DENIAL OR DELAY OF PAYMENT.



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TELL US ABOUT THE INJURY/ACCIDENT

Where did it happen?

When did it happen?
(If multiple days, list the earliest date)

How did it happen?
(Brief description)

WORK INFORMATION

Did this happen when you were at work?

Yes No

Has a Workers' Compensation claim been filed?

Yes No

OTHER INSURANCE

Is there other insurance involved?
(Homeowners, Auto, etc.)

Yes No

RESPONSIBILITY

Is another person or their insurance responsible
for this accident/injury?

Yes No

Do you plan to seek payment from another person
or their insurance? (For example, by filing a claim or lawsuit?)

Yes No

LEGAL REPRESENTATION

Have you hired an attorney for this accident/injury?

Yes No

Attorney Name (if applicable) _____

Attorney Phone Number (if applicable) _____

SIGNATURE

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

Date

Printed Name

Phone Number