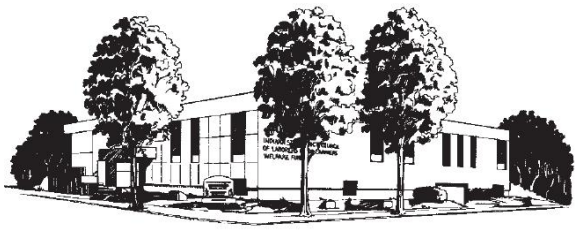

INDIANA LABORERS WELFARE FUND
P.O. Box 1587 • Terre Haute, IN 47808
Phone: (812) 238-2551 | Fax: (812) 238-1563
www.indianalaborers.org | info@indianalaborers.org

Name

Address

City/State/Zip Code

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