



INDIANA LABORERS WELFARE FUND

P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587

Telephone (812) 238-2551 Fax (812) 238-2553

www.indianalaborers.org

ACCIDENT INFORMATION FORM

Patient Name: _____

Date of Accident/Injury: _____

Claim Reference Number: _____

Diagnosis/Condition: _____

Anthem/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