

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK, SUITE 200

BURLINGTON, MASSACHUSETTS 01803-5201

TELEPHONE: (781) 272-1000 or (800) 342-3792 FAX: (781) 238-0703

MEMBER INFORMATION

Member Name: _____ Member ID#: _____

Patient: _____ D.O.B. _____

Phone # where you may be reached: _____

Address: _____

**** ACCIDENT & INJURY QUESTIONNAIRE ****

Dear Member,

1. Please provide **Claim Number(s)** _____
(**or** include a copy of your EOB)

2. **HOW** did this injury occur? Explain/details: _____

3. **WHEN** did this injury occur? **DATE:** _____

4. **WHERE** did this injury occur? _____

5. **WHAT** are your injuries? _____

6. If this claim is not due to an accident/injury, please explain why you needed this procedure? _____

Continue on other side

7. Was this Accident/Injury related to: Auto Accident _____ School activity _____
Employment _____ Other _____

8. List any other family members involved in this accident. _____

9. Have you or do you plan to retain an Attorney to file a claim against another party involved in this injury? Yes _____ No _____

If YES, please provide Name, Address & Phone # of your Attorney:

10. Has this case already been settled? Yes _____ No _____

The information provided on this form is true and complete to the best of my knowledge.

Signature of:

Member: _____ Date: _____

Patient: _____ Date: _____

Please mail or fax this form to the address above Attention: CLAIMS DEPT.
so that your claims can be processed in a timely manner.