

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: _____ MLBF ID#: _____

Patient: _____ D.O.B. _____

Phone # where you may be reached: _____

Address: _____

**ALL INFORMATION IS REQUIRED IN ORDER FOR CLAIMS TO BE PROCESSED
OR FORM WILL BE RETURNED.**

Dear Member, Was your injury a result of:

1) **Motor Vehicle Accident?** Yes ___ No ___
If yes, List any other injured family members _____

Employment? Yes ___ No ___
If yes, did you report it to your employer? Yes ___ No ___

Other? Please Circle: Slip & Fall, Assault, Dog bite, Public place or event,
School activity, Vacation, Rental property, Etc.

2) If this claim is **not** due to any of the above, please explain why you needed this
procedure? _____

3) **Please provide Claim Number(s)** or Dates of Service _____
(**or** include a copy of your EOB) _____

4) **HOW** did this injury occur? Explain/details: _____

5) **WHEN** did this injury occur? **DATE:** _____

Continue on other side

6) **WHERE** did this injury occur? _____

PLACE _____

7) **WHAT** are your injuries? _____

8) 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:

9) Has this case already been settled? Yes _____ No _____
If Yes, When _____

*** If you decide to pursue legal action, you MUST notify The Fund immediately or your benefits may be denied.**

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.