CENTRAL LABORERS' WELFARE FUND
P.O. Box 1267 Jacksonville, IL 62651
ACCIDENT/ILLNESS CLAIM FORM

Central Laborers' Welfare Fund has received a claim(s) from your physician/hospital/other provider that contains a diagnosis code that could be related to an accident or illness.
PLEASE COMPLETE ALL SECTIONS OF THIS FORM AND RETURN IT TO THE FUND OFFICE SO WE MAY PROCESS YOUR CLAIM(S).
*******BOTH SIDES MUST BE COMPLETED AND FORM MUST BE SIGNED*******

Participant Name: ________________________ Patient Name: ________________________
Participant SS# or ID #: ____________________ Patient's Date of Birth: ____/____/____

PART OF THE BODY INJURED/AFFECTED (Please mark all areas involved)

____Head ____Face ____Eye ____Ear ____Nose ____Mouth ____Tooth/Teeth
____Neck ____Chest ____Abdomen ____Upper-Back ____Mid-Back ____Lower-Back
____Shoulder (R or L) ____Arm (R or L) ____Wrist (R or L) ____Hand (R or L)
____Leg (R or L) ____Knee (R or L) ____Ankle (R or L) ____Foot (R or L) ____Other

ABOUT THE ACCIDENT (If this was not an accident, please complete Section A)

Date of Accident/Illness: ____/____/____ Time of Accident/Illness: ____:____ a.m or p.m.
1. No injury/Illness____(Complete Section A,H)
2. Home ____(Complete Section B,G,H)
3. Work ____(Complete Section C,G,H)
4. School____ (Complete Section D,G,H)
5. Motor Vehicle____ (Complete Section E,G,H)
6. Other Injury____ (Complete Section F,G,H)

SECTION A – ILLNESS

Describe your condition/illness: ____

SECTION B – HOME

Homeowner's Name: ____________________
Address ________________________________
____
Describe the incident ____________________
____
____
Was this your home: Yes No
Other Insurance involved: Yes No
If yes, please complete the following:
Insurance Company: ____________________
Policyholder: ________________________
Policy Number: ______________________
Attorney involved: Yes No
(If yes, please complete Section G)

YOU MUST INCLUDE A STATEMENT SHOWING ALL HOME POLICY PAYMENTS

SECTION C – WORK

(This includes Self-employment)

Employer's Name: ____________________
Address ________________________________
____
Describe the incident ____________________
____
____
Has the injury been reported to your employer: Yes No
Has you employer filed with their worker's compensation insurance: Yes No
If yes, please complete the following:
Insurance Company: ____________________
Policyholder: ________________________
Policy Number: ______________________
Attorney involved: Yes No
(If yes, please complete Section G)

SECTION D – SCHOOL

Name of the School: ________________________ Do you have school/sport insurance: Yes No
Have you filed a claim against your school Insurance: Yes No
____Sport Related _____Bus Related ____Fight ____Other
Describe the incident ____
Attorney Involved: Yes No (If yes, please complete Section G)

YOU MUST INCLUDE A STATEMENT SHOWING ALL SCHOOL/SPORT PAYMENTS

SECTION E – MOTOR VEHICLE

(Submit a copy of the Police Report)

Were you the:

____Driver ____Passenger ____Pedestrian

Describe the incident:

____

Was the accident reported to the police: Yes No

Were any tickets issued: Yes No

Your Insurance Company: ____________________

Company Phone Number: ( )_____-______

Policyholder: ______________________________

Policy Number: ____________________________

Other party's auto Insurance information:

Name of the Driver: _________________________

Insurance Company: ________________________

Company Phone Number: ( )_____-______

Policyholder: ______________________________

Policy Number: ____________________________

Attorney involved: Yes No (If yes, complete Section G)

YOU MUST INCLUDE A STATEMENT SHOWING ALL AUTO POLICY PAYMENTS

SECTION F – OTHER

Fight, Dog Bite, Accident/Injury at a Place of Business, other Accident or injury

(Submit a copy of the Police Or Other Report if filed)

Describe the incident: _______________________

____

Location: _________________________________

Other party's Insurance information:

Insurance Company: ________________________

Company Phone Number: ( )_____-______

Policyholder: ______________________________

Policy Number: ____________________________

OTHER

Describe the incident _______________________

____

____

Other person(s) involved: ___________________

____

Attorney involved: Yes No (If yes, complete Section G)

YOU MUST INCLUDE A STATEMENT SHOWING ALL THIRD PARTY PAYMENTS

SECTION G – ATTORNEY INFORMATION

Attorney Name:____ _____________________

Attorney Address:____

Attorney Phone Number: ____

Have you been offered a settlement: Yes No

(If you have received a settlement – include a copy of the settlement agreement)

SECTION H – REQUIRES YOUR SIGNATURE

ACCEPTANCE OF BENEFITS UNDER THE CENTRAL LABORERS' WELFARE PLAN SIGNIFIES ACCEPTANCE OF ALL TERMS AND CONDITIONS AS DEFINED IN THE CENTRAL LABORERS' WELFARE FUND REIMBURSEMENT AGREEMENT AND THE SUBROGATION AGREEMENT AND PURSUANT TO THE POLICY FOR REIMBURSEMENT AND FOR SUBROGATION DOCUMENTED IN THE CENTRAL LABORERS' WELFARE FUND SUMMARY PLAN DESCRIPTION.

BY MY SIGNATURE, I SIGNIFY THAT I HAVE READ AND UNDERSTAND AND AGREE TO THE TERMS OF THE CENTRAL LABORERS' WELFARE FUND RIGHT OF RECOVER/SUBROGATION AGREEMENTS AND AM PROCEEDING IN MAKING APPLICATION FOR BENEFITS ON BEHALF OF MYSELF OR MY DESIGNATED DEPENDENT(S) WITH THE UNDERSTANDING AND KNOWLEDGE THAT THE FUND WILL PAY BENEFITS, IF ANY ARE OWED, IN ACCORDANCE WITH NORMAL PLAN PROVISION; I FURTHER CERTIFY THAT THE INFORMATION PROVIDED REGARDING THIS ACCIDENT/INJURY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IN THE EVENT THAT I OR MY DEPENDENT(S) RECOVER DAMAGES AND OR IS AWARDED COMPENSATION AS A RESULT OF MY OR MY DEPENDENT'S INJURY OR ILLNESS I OR MY DEPENDENT(S) WILL FULLY REIMBURSE CENTRAL LABORERS' WELFARE FUND UPON RECEIPT OF SAID MONIES AFTER SETTLEMENT AND/OR ADJUDICATION MADE BY THE PROPER AUTHORITIES; AND THAT I OR MY DEPENDENT WILL COOPERATE FULLY IN DOING WHAT IS REASONABLE AND NECESSARY FOR THE FUND TO RECOVER AND I OR MY DEPENDENT WILL NOT TAKE ANY ACTION, WHICH WOULD PREJUDICE THE FUND'S RECOVERY. I ALSO UNDERSTAND THE PLANS HAS THE RIGHT TO RECOVER OR SUBROGATE 100% OF THE BENEFITS PAID OR TO BE PAID BY THE PLAN ON MY OR MY DEPENDENT'S BEHALF TO THE EXTENT OF ANY AND ALL OF THE FOLLOWING PAYMENTS: ANY JUDGMENT, SETTLEMENT OR ANY PAYMENT MADE OR TO BE MADE BECAUSE OF AN ACCIDENT, INCLUDING BU NOT LIMITED TO OTHER INSURANCE. THE PLAN HAS FIRST PRIORITY WITH RESPECT TO ITS RIGHT TO REDUCTION, REIMBURSEMENT AND SUBROGATION FROM THE AMOUNT OF MONETARY RECOVERY. YOU OR YOUR DEPENDENTS AND YOUR ATTORNEY (IF YOUR ATTORNEY IS HOLDING THE MONETARY RECOVERY) SHALL BE FIDUCIARIES WITH RESPECT TO THE MONIES HELD IN CONSTRUCTIVE TRUST.

Signature: ___________________________________ Date: ______________________________

(Signer must be 18 years of age – If under 18 year of age – Participant's signature is required)

Address: ____

Telephone Number (Home): __________________________ (Work): ______________________

Signature Witnessed By: ____________________________________ Date: ____________________

A COPY OF THE SUBROGATION/REIMBURSEMENT LANGUAGE IS LOCATED IN YOUR SUMMARY PLAN DESCRIPTION. YOUR SIGNATURE INDICATES THAT YOU HAVE LOCATED, READ AND AGREE TO THE TERMS OF THOSE POLICIES.