

SEIU Local 1 & Participating Employers Health Trust

ACCIDENT REPORT

TO BE COMPLETED BY INSURED MEMBER:

Please answer all questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

Member's Full Name _____ Sex _____

Address _____ City _____ State _____ Zip _____

() _____
Home Phone Number _____ UID Number _____ Date of Birth _____

Member's Marital Status:

_____ Single _____ Divorced
_____ Married _____ Widowed
_____ Separated

Employer Name _____ Occupation _____ Date of Employment _____

Claimant: _____ Self _____ Spouse _____ Child

Name of Disabled _____ Sex _____ Date of Birth _____

IF CLAIMANT WAS INJURED:

Date of Accident _____ Time _____ Was Claimant at work when accident occurred? _____

Name of Claimant's Employer: _____

Please give a detailed description of the accident on the reverse side of this form telling how, when, and where the accident occurred.

Type of Insurance: _____ Home _____ Auto _____ Your Insurance Carrier _____

Other Party Liability Insurance Carrier / Policy Number _____

Have you hired an attorney to represent you in this matter? _____

Attorney's Name and Telephone Number _____

If you have lost time from work, please describe disability and indicate whether you have claimed or are claiming disability benefits.

Please submit a copy of the police or motor vehicle accident report if available.