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.

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