SEIU Local 1 & Participating Employers *Health Trust*

111 E. Wacker Drive . 17th Floor . Chicago, IL 60601 . Telephone (312) 233-8888 . Facsimile (312) 233-8839 . Website www.seiu1benfunds.org

ACCIDENT FORM

Dear Participant:

The SEIU Local 1 & Participating Employers Health Trust has received claim(s) for you or your dependent which may be related to an accident. To accurately process the claim(s), please complete and sign this form, and return it with the required documentation to the Fund Office.

Please note that your claim CANNOT BE CONSIDERED FOR PAYMENT UNTIL THIS INFORMATION AND ALL REQUIRED DOCUMENTS ARE RECEIVED BY THE FUND OFFICE.

Today's Date:	Participant Name:	Participant ID or SSN:
Address:	City, State Zip:	
Phone Number:	Email Address:	Date of Birth:
Injured Party (if not Participant):	Relationship to Participant:	Date of Birth:

Type of Case (select one):
☐ Auto/Motorcycle Accident ☐ Worker's Compensation ☐ Other Injury or Illness (describe): ____________________________

Date of injury or illness:	Where did the injury occur?:

Describe the injury and how it happened (use the back of this form if needed):

Were the police called? ☐ Yes ☐ No **(if yes, provide a copy of the police report with this form)**

Have you hired an attorney to represent you in this matter? ☐ Yes ☐ No **(if yes, provide the information below)**

Attorney Name:	Attorney Phone Number:	Case number:	
Attorney Address:	City:	State:	Zip:

Name of other party involved in the accident:	Other party phone number:

Other party's insurance carrier information:

Insurance name:	Insurance phone number:		
Insurance address:	City:	State:	Zip:

For **Auto/Motorcycle, Other Injury, or Illness** claims, please provide copy(ies) of the following:

***Copies of Explanation of Benefits (EOB) for any bills paid by the other party's insurance company**

***Copy of the Police Report**

For "**Work Related**" claims, please complete the following information:

Have you filed a Worker's Compensation claim? ☐ Yes ☐ No

Has your worker's compensation claim been accepted or denied? ☐ Accepted ☐ Denied

If your worker's compensation was denied, please provide a copy of your **Worker's Compensation Denial Letter**

I CONFIRM THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

______________________	__________	______________________	__________
Injured Party signature	Date	Participant signature (if injured party is a minor)	Date

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