BEER INDUSTRY-LOCAL UNION NO. 703
HEALTH AND WELFARE FUND
18660 GRAPHIC DRIVE, SUITE 202, TINLEY PARK, IL 60477
T: 708-429-0046 ** www.cbibf.org** F: 708-429-0047

Accident/Injury Questionnaire

PLEASE PRINT

Participant Name:_____ **Participant SSN: XXX-XX-**_____

Street Address: _____ **City / State:** _____

Patient Name: _____ **Date of service** _____

PLEASE RETURN THIS QUESTIONNAIRE WITHIN 10 DAYS
UNANSWERED QUESTIONS WILL DELAY BENEFIT CONSIDERATION UNTIL THE MISSING INFORMATION IS OBTAINED.

TO BE COMPLETED BY INJURED PARTY, IF UNDER AGE 18, HAVE PARENT COMPLETE FORMS

1. Was medical treatment the result of an accident or injury? Yes ( ) No ( )
2. If your answer is yes, Date of accident and/or injury: _____ Please complete this questionnaire.
3. If your answer is no, please explain reason for medical treatment, sign and date and return to Fund Office:

_____

_____

4. **Did injury occur at home** Yes ( ) No ( ) If yes, complete section #9
5. **Did injury occur because of an automobile accident?** Yes ( ) No ( ) If yes, complete section #9,#10
6. **Did injury occur on another person's property?** Yes ( ) No ( ) If yes, complete Section #11
7. **Did injury happen while working?** Yes ( ) No ( ) If yes, complete section #12
8. **Other** Yes ( ) Please explain:

_____

_____

_____

9. **Provide a brief description of the accident and/or injury and a copy of any accident reports (i.e. police reports):**

_____

_____

_____

10. **Complete this section if injury occurred due to an automobile accident:**
Patient was: Driver ( ) Passenger ( ) Pedestrian ( )

Your Auto Insurance Company Name and Address:_____

_____

Adjuster's Name and Telephone Number: _____
Claim Number: _____
Driver of Other Vehicle(s) Name: _____
Insurance Company Name, Copy of Auto Insurance Card, Claim Number, Address, and Adjuster Information:

_____

_____

_____

11. Complete this section if injury occurred on another person's property:

Name of property owner: _____

Property owner's insurance company name and address: _____

_____

Adjuster's name and telephone number: _____

Claim Number: _____

12. Complete this section if injury occurred while you were working:

Did you file a report of injury with your employer? Yes ( ) No ( )

Were you off work due to this injury? Yes ( ) No ( )

If so, have you returned to work Yes ( ) Date you returned _____ No ( )

13. Does an attorney represent you in this matter? Yes ( ) No ( )

If you answered yes, please provide attorney's name, address, and telephone number: _____

_____

_____

If an attorney is obtained, you must notify us as soon as possible.

☐ **THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE**

Signature _____Telephone Number _____Date_____