Electricians Health, Welfare & Pension Plans

I.B.E.W. LOCAL UNION NO. 995
8111 TOM DRIVE BATON ROUGE, LOUISIANA 70815
(225) 927-6340 FAX (225) 927-6344
1-800-324-0995

ACCIDENT QUESTIONNAIRE

A.) **MEMBER NAME:** Claim for: Self Spouse Dependent Child

Patient's Name: Male Female Date of Birth Social Security Number

Is patient age 18 or over? *Y N* If yes, are they insured by another Health Plan? *Y N*
(*dependent children only) (***If so, please provide copy of other insurance card)

B.) **CLAIM INFORMATION:**

Is claim related to: ___Illness ___Accident/Injury ___Auto Accident (Subrogation)

If claim is related to an accident/injury or auto accident please provide a brief description:

How:_____

Date:_____ Where:_____

Is another party legally/financially responsible for this accident: ___Yes ___No

If yes, explain:_____

Does the accident, illness, or injury result from patient's occupation? ___Yes ___No

I hereby authorize any dentist, physician, hospital, insurance company, organization, or employer to release my information including full copies of their records to the IBEW Local 995 for any medical treatment, services, or benefits rendered or payable to me or on my behalf. A photostat of this authorization shall be as valid as the original. I hereby certify that the foregoing answers are true and correct to the best of my knowledge. Whoever, in any document required by Title I of the Employee Retirement Income Security Act of 1974 makes any false statement or representation of fact shall be fined not more than $10,000, or imprisoned not more than five years, or both.

Patient's Signature* Member's Social Security No. Date
(*Authorized Representative if under age 18)

**** Must be completed, signed and returned in order for your claim to be processed.

Accident/Visit Date_____Provider_____Diagnosis_____