Laborers' Metropolitan Detroit Health Care Fund

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ACCIDENTAL INJURY QUESTIONNAIRE

Participant's Name_____ SS#_____

Patient's Name/Relationship_____

Provider(s) of Service_____

Date(s) of Service_____

Type of Injury_____

Additional information is needed regarding this claim. Please complete this questionnaire and return it in the enclosed envelope.

When did the accident happen?_____
(Please give date and approximate time of accident)

Exactly where did the accident happen?_____

Was the person hurt on the job? _____ Yes _____ No

If yes, was a Worker's Compensation Claims filed? _____Yes _____ No

How did the accident happen?

_____

_____

_____

_____

_____

_____

_____

Please indicate the name and telephone number of a family member that can be contacted between 8:15 a.m. and 4:30 p.m., if more information is needed regarding this claim.

_____ _____

Name of contact Person Telephone Number

_____ _____

Participant's Signature Date