CHICAGO LABORERS' DISTRICT COUNCIL RETIREE HEALTH and WELFARE FUND

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DEPENDENT ACCIDENT CLAIM FORM

Failure to complete this form in full may result in delay of payment of your claims.

EMPLOYEE/DEPENDENT INFORMATION:

Employee's Name: Social Security Number: ___________________________

Home Address: ____

City, State, Zip Code: ________________________________ Phone: (____) _______________

Dependent's Name: Gender: Male ☐ Female ☐

Dependent's Social Security Number: ___________________________ Dependent's Date of Birth: ___________________

Date of Claim: ______________________________

CLAIM/ACCIDENT INFORMATION:

Describe the injury/reason for the doctor visit: ____

____

____

Date of Accident: ______________________________ Time of Accident: ___________________________

Is the injury/accident work related? Yes ☐ No ☐

Where did accident occur? ____

____

If the accident occurred at school, please complete the following:

School Name: ____

School Address/City: ____

Contact Name: ___________________________________ Phone: (____) __________________________

Was another party involved in the accident? Yes ☐ No ☐

Name: ____ Phone: (___) ___________________________

Address: ____

Do you plan to seek reimbursement from the other party? Yes ☐ No ☐

The above answers are true and correct to the best of my knowledge:

Claimant's Signature: _______________________________________ Date: ___________________________
(Parent or legal guardian if claimant is a minor)

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result from such act.