GROUP: 060	www.silehw.org	Group Name: Southern Illinois Laborers

ACCIDENT/INJURY REPORT

PLEASE ANSWER ALL QUESTIONS-UNANSWERED QUESTIONS WILL DELAY BENEFIT COVERAGE OR RESULT IN A DENIAL OF BENEFIT COVERAGE UNTIL THE MISSING INFORMATION IS PROVIDED BY YOU TO THE FUND.

Insured's Full Name:	Insured's ID Number:
Patient's Full Name:	Patient's Birth Date:
Home Address:	Telephone Number:
City/State/ZIP:	Date of Service:
Email Address:	
Was this a work related injury? ☐ Yes ☐ No	Have you filed a work comp claim? ☐ Yes ☐ No Will you file a work comp claim? ☐ Yes ☐ No

Is this accident related to a motor vehicle (i.e. automobile, bus, motorcycle, ATV, motorized bike) or did a third party cause the accident? ☐ Yes ☐ No

Name of Other Party to Accident:	
Address:	City/State/ZIP:
Insurance Company:	Agent's Name:
Address:	City/State/ZIP:
Telephone Number:	Policy Number:
Were Police Called? ☐ Y ☐ N	**If yes, please provide a copy of the report.**

Were you issued a ticket or were charges filed against you? ☐ Y ☐ N

If yes, please provide a copy of the ticket and/or describe the nature of the charges.

Was this an accident that happened on someone else's property? ☐ Y ☐ N

Name of Other Party to Accident:	
Address:	City/State/ZIP:
Insurance Company:	Agent's Name:
Address:	City/State/ZIP:
Telephone Number:	Policy Number:

If you answered YES to any of the above questions, explain in detail below.
If you answered NO to all of the above questions, please explain why you required medical attention (i.e. I fell at home or on the parking lot at Kroger)

Have you hired an attorney for you in this matter? ☐ Y ☐ N

Attorney's Name:	Telephone:
Address:	City/State/ZIP:

SIGNATURE OF INSURED: **DATE:**

SIGNATURE OF DEPENDENT
(Patient or Guardian): **DATE:**

Please return this form to: SOUTHERN ILLINOIS LABORERS' AND EMPLOYERS' HEALTH & WELFARE FUND
PO BOX 40
CARTERVILLE, IL 62918
618-998-1300 FAX 618-993-8295
www.silehw.org

If you have any questions, please contact the Claims Department at the above telephone number.