I.B.E.W. Local Union No. 124
Health and Welfare Fund
305 E 103rd Terrace
Kansas City, MO 64114
816-943-0277

Re: Patient Name:
Member ID:
Claim ID:
Date of Service:
Injury/Illness:

Dear Sir or Madam,

We are in receipt of a claim for benefits for the above listed member. In order to process this claim correctly, we are in need of accident information. Please complete the following questions and return this form to the Fund Office at the address noted above or you may fax it to 816-943-8983.
Thank you for your prompt response and help in resolving this outstanding claim. If you have any questions, please contact the Fund Office at 816-943-0277. We appreciate your assistance.

Date of Accident: _____ Place of Accident: _____

Details of Accident: _____

_____

Was the patient at work when the accident happened? ☐ YES ☐ NO

Have you filed this claim with the Workers Compensation Carrier? ☐ YES ☐ NO

Was this a Motor Vehicle accident? ☐ YES ☐ NO

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish I.B.E.W. L.U. 124 Health & Welfare Fund information regarding treatment rendered.

Member signature: _____ Date: _____

Spouse signature: _____ Date: _____