

Plumbers & Pipefitters Local 344 Health & Welfare Fund

8441 Gulf Freeway Suite 304 · Houston, TX 77017
Phone (713) 643-9300 · 866-236-3148 · Fax (866) 316-4794

Injury Report

All questions must be completed by the Participant.
If any of the questions do not apply, please indicate so by answering with an N/A for not applicable. Please return the signed form to the address listed above or fax to 1-866-316-4794

Please complete the following questions.

Participant's name _____ Phone No. _____ UID or SSN _____

Patient's name _____ Date injury occurred _____

Please describe how, when and where injury occurred _____

Did this injury occur as a direct result of your employment and while on the job? Yes No

If yes, return this form and file any related claims directly with your employer's worker's compensation carrier.

Please complete the following questions if the injury was the result of an automobile accident or other incident caused by a third party. No claims can be processed until all information requested below is received.

Please list name(s) of other party(ies) involved in the incident _____

Insurance company of other party _____ Phone No. _____

Address _____ Claim No. _____

Were police called? Yes No Was accident report completed by police? Yes No

If a report was completed, please attach a copy to this form.

Were charges lodged against you? Yes No

Were charges lodged against the other party? Yes No

Have you hired an attorney to represent you in this matter? Yes No

If yes, attorney's name _____ Phone No. _____

Address _____

Participant's signature _____ Date _____