ELECTRICAL WORKERS LOCAL 369

BENEFIT AND RETIREMENT FUND

906 MINOMA AVENUE
LOUISVILLE, KY 40217

PHONE:502-635-2611
FAX:502-637-3444
TOLL FREE: 800-427-2495

DATE:

NOTE: CLAIMS RELATED TO THIS **DIAGNOSIS WILL NOT BE PAID UNTIL WE RECEIVE THIS INFORMATION**

NAME:
ADDRESS

Claimant: Policy Number:
Member: Service Date:

We are in receipt of your recently submitted claim. However, before any further consideration can be given to your claim, we will need the following information:

This claim was submitted for

Section A (Complete in full)

Did this incident happen while working?	YES	NO
Was this due to an auto accident?	YES	NO
Was someone else at fault?	YES	NO
Happen on another person's property?	YES	NO

Please provide a detailed explanation of how the incident occurred. List all injuries sustained from the incident. Attach a copy of any police or accident reports.

_____

_____

_____

Please provide a phone number where you may be reached from 8:00 a.m. to 4:30 p.m. Monday through Friday if additional information is needed: _____

Signature of dependent_____Date_____
If a minor, signature of parent or legal guardian.

Signature of Employee_____Date_____

If you answered YES to any of the above questions, please complete Section B.

SECTION B:

Location of the incident: _____

_____

Street Address City State

Name and address of the other party at fault:

Name_____

Street Address_____

City_____State_____Zip Code_____

Name, address, telephone number and policy number of the other party's insurance company:

Policyholder's Name_____

Insurance Co. Name_____

Street Address_____

City_____State_____Zip Code_____

Phone Number_____Policy Number_____

Name, address, telephone number, and policy number of your auto or homeowner insurance carrier:

Policyholder's Name_____

Insurance Co. Name_____

Street Address_____

City_____State_____Zip Code_____

Phone Number_____Policy Number_____

Are you pursuing legal action, damages or other recovery from another party for the charges related to this incident? YES NO

If yes, please provide the name, address and telephone number of your legal representative:

Name_____

Street Address_____

City_____State_____Zip Code_____

Phone Number_____

Please be advised the Electrical Workers Local 369 Benefit Fund Plan document contains a Subrogation Reimbursement/Right of Recovery provision for charges, which may be the result of the negligence of another party. The plan contains a Coordination of Benefits provision, which may also be applicable to these charges. Acceptance of benefits from the Plan automatically assigns to it any rights the covered person may have to recover benefits from any other party. Please review your Plan for additional explanation.

Therefore, in order to properly process charges for any available benefits, in accordance with the Plan guidelines, we require accident information.

No further payments will be made on any related expense until we receive this completed form. Please return it within ten (10) days.

It is possible benefits may be paid on behalf of the patient, under the Plan of which I am a participant. I agree not to release any third party or their insurer without prior written approval from the Plan, and will take no action, which may prejudice or jeopardize the Plan's right for this claim, and either the Plan or I may pursue a claim against the other party.

Signature of dependent_____Date_____
If a minor, signature of parent or legal guardian.

Signature of Employee_____Date_____

Please return this letter with the requested information to our office. When received, your claim will be given prompt consideration.

Sincerely,
Claims Department
Ida