Sheet Metal Workers Local 91 – Health and Welfare Fund

8124 - 42nd St., West
ROCK ISLAND, ILLINOIS 61201
Phone 309-787-0695 Ext. 18
Fax 309-787-2234

Dear Member:

Sheet Metal Workers Health & Welfare Fund is requesting information about the medical services provided for the patient and treatment date as shown below.

- Patient Name: ____
- Treatment Date: ___________Type of Injury: ____________________
- Medical Provider: ____

Sheet Metal Workers Local 91 Health & Welfare Fund would like to know if these medical services were related to an accident, a workplace injury or an occupational illness. Your claim will not be processed until we receive the necessary information.

Please complete and sign the enclosed questionnaire and mail it to us, within the next 10 days, using the enclosed postage-paid envelope.

As you may know, when a third party is responsible for an injury or illness, Sheet Metal Workers Local 91 Health & Welfare Fund has the right, and the responsibility to its members to seek repayment for the treatment of that injury or illness. Your help in this matter will allow your Health Plan to keep its costs as low as possible.

If treatment was for an accident or workplace injury, do not disregard this letter. Please note on the attached form that it is a Workers' Comp claim so we will stop our investigation. The Providers will be notified to submit your claims to the Workers' Comp Insurance.

If you have any questions, please contact the Sheet Metal Workers Local 91 Health & Welfare Office between 8:00 a.m. to 4:30 p.m., Monday through Friday.

Sincerely,

Member Services
Sheet Metal Workers Health & Welfare Fund

Claim Information

Patient's Name______________________________________ Home Phone #:(   ) ____________
Address________________________________City______________State ______ Zip __________
SS#:______________________ Birth Date: ____/____/______ Sex: M F (please circle one)

What was Patient's Treatment for? (Please check one below)

____Illness/Condition Please describe:__________________________________
____Injury at Home Please describe:__________________________________
____Motor Vehicle Complete Section I & II
____Work Related Injury/Condition Complete Section I & III
____Injury at Other Location. Complete Section I & IV

Section I

Accident Location Date of Injury or Onset__________________
Address___________________________City ___________________County________ State_________
Was Police Report Made? ___Yes ___No Name of Police Dept. ____________________
Accident Details ____

Continue with details on reverse side or attach additional sheet if necessary.

Section II Auto

Your Auto Insurance Co.______________________ Policy in the Name of:__________________
Address:__________________________ City _____________________State_______ Zip__________
Did you file a Claim with your Insurance Co.? _____Yes _____No
Name of Other Driver________________________________Phone No (______)______________
Address___________________________ City _____________________State______Zip__________
Owner of Vehicle:___________________________________Phone No (_____)_______________
Address ___________________________ City_____________________ State _____ Zip__________
Their Auto Insurance Co:_____________________ Policy in the Name of:__________________
Did you file a claim with their Insurance Co? ____ Yes ____ No Adjusters Name______________

Section III – Workers Comp

Employer's Name____________________________________ Phone Number (_____)____________
Address___________________________ City ____________________ State ______ Zip __________
Did you file a Work Comp Claim? _____Yes _____No Employer Contact ___________________
Work Comp Insurance Co: ____________________________ Phone Number (_____)____________
Address: _________________________ City____________________ State ______ Zip__________

Section IV - Property

Name of Property Owner: ______________________________ Phone Number (_____) ___________
Address:__________________________ City _____________________ State ______ Zip __________
Owner's Insurance Co:____
Did you file a claim? _____Yes _____No

Attorney Information: Complete if Attorney is handling this claim.

Attorney Name:____________________________________ Phone Number (_____) _____________
Address:__________________________ City _____________________ State ______Zip ___________

Signature: ____ Date:____________________