

GROUP: 060

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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.**

Member's Full Name:	Member'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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you filed a work comp claim? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Will you file a work comp claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Was an accident report prepared by the police?  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 MEMBER:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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

Please return this form to: SOUTHERN ILLINOIS LABORERS' AND EMPLOYERS' HEALTH & WELFARE FUND  
5100 ED SMITH WAY, SUITE A  
MARION, IL 62959  
618-998-1300 FAX 618-993-8295  
[www.silehw.org](http://www.silehw.org)

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