Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund

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Sparks, Maryland 21152-9451
Telephone: (800) 730-2241
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
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ACCIDENT INQUIRY FORM

PARTICIPANT'S NAME _____

ADDRESS _____

PATIENT'S NAME _____

LAST FOUR DIGITS OF PARTICIPANT'S SOCIAL SECURITY NUMBER _____

CLAIM NUMBER _____

RELATIONSHIP _____ ACCOUNT # _____

DATES OF SERVICE _____ TOTAL BILLED _____

DIAGNOSIS _____

_____

We have received your medical claim. As your claim processor, we have the responsibility to be sure any other party which may be liable for your injury makes payment or acknowledges its liability before the Fund makes payment. We appreciate your cooperation in supplying us with the information requested below. **Please return this form promptly using the enclosed pre-addressed envelope. We will process your claim promptly upon receipt of this information.**

It appears you may have had an accident injury. This may be a car accident or any slip, fall, strain, sprain or any unexpected mishap which is not an illness. Did you have an accidental injury? YES_____ NO_____

If no, go to the end of this form to sign, date, and return it. If yes, complete the questions below:

1. When, where, and how did the accident occur?

   _____

   _____

2. What is the name and address of any other injured person or party?

   _____

3. If you have it, what is the insurance company name and Policy Number for the other party?

   _____

[OVER]

4. If your insurance company may be liable, what is your insurance company name and Policy Number?

   _____

5. Are you pursuing a lawsuit for this injury?

   _____

If no other party was in any way liable for your injury, please write that in a statement below, sign and date your statement, and return this form to the Fund office in the enclosed pre-addressed envelope.

Please return this information as quickly as possible. If you used an in-network provider, we must be able to process your claim within 30 days to get the discount so we encourage your prompt reply.

Because the information necessary to process your claim is not yet complete, it is denied as submitted. However, once all information necessary for processing has been received, the claim will be re-opened, as long as it is within the original filing deadline. You may appeal any full or partial denial by writing to the Board of Trustees within 180 days from the date of the denial.

Other claims which may be related to this claim will be similarly delayed or denied until the information in this request is returned to us.

Sincerely,

The Fund Office

Your signature is required to acknowledge that you have read the contents of this letter. Please sign and date below.

Signature of Participant: _____

Signature of Patient, if Patient is not the Participant: _____

Note: The participant must sign if the patient is under age 18. If the patient is under age 18, only the participant is required to sign (not the minor child).

Write your statement below if you are affirming that no other party was in any way liable for your injury.

_____

_____

_____