ACCIDENT REPORT

Answer all questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

EMPLOYEES FULL NAME: ______________________________ SEX: _______
HOME ADDRESS: ____
CITY: ____________________________ STATE: _______ ZIP CODE: _______
HOME TELEPHONE NUMBER: ______________
DAYTIME TELEPHONE NUMBER: ______________

SOCIAL SECURITY NO.: _______________________ DATE OF BIRTH _______
EMPLOYEE'S MARITAL STATUS:
___SINGLE ____DIVORCED ___MARRIED ___WIDOWED _____SEPARATED

EMPLOYED BY: __________________________ OCCUPATION______________
DATE OF EMPLOYMENT:___________________
CLAIM IS MADE FOR: ________SELF __________SPOUSE __________CHILD

____
NAME OF DISABLED PERSON IF OTHER THAN EMPLOYEE   SEX   D.O.B.

DATE ACCIDENT OCCURRED____________________TIME__________________

WAS CLAIMANT AT WORK WHEN ACCIDENT OCCURRED: ____YES _____NO
NAME OF CLAIMANT'S EMPLOYER:___________________________________
DETAILED DESCRIPTION OF ACCIDENT (use reverse side and tell how, when, and where it occurred)

TYPE OF INSURANCE HELD BY OTHER PARTY: HOME_______AUTO_______
YOUR INSURANCE CARRIER: HOME ____________ AUTO ________________
OTHER PARTY LIABILITY INSURANCE CARRIER _________________________

HAVE YOU HIRED AN ATTORNEY TO REPRESENT YOU IN THIS MATTER?
__________ YES ___________ NO
IF YES, HIS (HER) NAME ______________________________________
COMPLETE ADDRESS: ____
____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete.

DATE CLAIM SIGNED: ______________________ LOCAL UNION NO.: ________

SIGNATURE: _________________________ SOCIAL SECURITY NO.___________