ACCIDENT OR INJURY REPORT

Railroad Maintenance and Industrial Health and Welfare Fund

PLEASE ANSWER ALL QUESTIONS – UNANSWERED QUESTIONS WILL DELAY BENEFIT CONSIDERATION UNTIL THE MISSING INFORMATION IS OBTAINED.

Insured's Full Name: _____

Insured's Social Security Number: _____

Patient's Full Name: _____

Patient's Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Date Accident Occurred: _____ Time Accident Occurred: _____

Place Accident Occurred: _____

Was Claimant at work when Accident Occurred? ☐ YES ☐ NO

Name of Claimant's Employer: _____

Address of Claimant's Employer: _____

City: _____ State: _____ Zip: _____

Please give a detailed description of the accident. Please include how, when, and where it occurred.

_____

_____

_____

_____

_____

_____

_____

Is this accident covered under any other coverage? (auto, medical payment, and/or third party liability, homeowners, workers' compensation, school insurance, etc.) ☐ YES ☐ NO

PLEASE ALSO COMPLETE REVERSE SIDE

Accident or Injury Report Continued

Name of other party to Injury/Accident: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Agent's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Policy Number: _____

Were Police Called? ☐ YES ☐ NO

Was an Accident Report prepared by the Police? ☐ YES ☐ NO
If yes please provide a copy of report

Were charges lodged against you? ☐ YES ☐ NO

If so, please describe the nature of the charges:

_____

_____

Was this accident Alcohol/Drug Related? ☐ YES ☐ NO
Have you hired an attorney in this matter? ☐ YES ☐ NO- If so, please provide name, address, and number below:

Attorney's Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____

SIGNATURE OF INSURED: _____ Date: _____

SIGNATURE OF DEPENDENT: _____ Date: _____

RETURN FORM TO:
RAILROAD MAINTENANCE AND INDUSTRIAL HEALTH AND WELFARE FUND
2725 West Monroe Street, Springfield, IL 62704