

Pipe Fitters' Local 597
WELFARE & RETIREMENT FUNDS

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ACCIDENT FORM

Member's Name

First Middle Initial Last

Social Security Number Local 597 Union Card Number

Address

Street City State Zip Code

Phone Number

E-Mail Address

Patient's Name

First Middle Initial Last

Regarding:

We need your help in supplying the following information before we can process the claim submitted.

Please explain why the patient sought medical attention.

Explanation: _____

Related to the Job: Yes No

If this was an accident please supply us with the additional information.

How: _____

When: _____

Where: _____

Are you filing a medical claim against any Auto, Property/Casualty Insurance? Yes No

If you have any questions, we will be pleased to answer them.

Member's Signature _____ Date / /