Construction Industry Laborers Welfare Fund

INITIAL REPORT OF CLAIMS

NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY

INSTRUCTIONS:

This form is to be completed by the member and attending physician. Be sure to include your Social Security Number and sign member's signature section.

RETURN COMPLETED FORM TO:

Construction Industry Laborers Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500
816-777-2669 | Fax 816-756-3659

MEMBER COMPLETES THIS SECTION:

Name of Member		Home Phone	
Date of Birth	Social Security Number	Occupation	
Employer			
Home Address	City	State	Zip Code
If claims is for member's disability, show date last worked:		Date resumed work:	

COMPLETE THIS SECTION FOR ALL CLAIMS:

Nature of Sickness or Injury:	Date Accident Occurred or Sickness Began:	Date First Treated:
If Hospitalized, Name of Hospital:	Date Admitted:	Date Discharged:

Did someone intentionally cause this injury? ☐ YES ☐ NO

Was injury due to an accident? ☐ YES ☐ NO

Did the accident happen on your property? ☐ YES ☐ NO If no, address where accident occurred:

Was this due to an auto accident? ☐ YES ☐ NO

Did injury or illness occur while at work? ☐ YES ☐ NO

Have you filed this claim under Workmen's Compensation? ☐ YES ☐ NO

Have you started a lawsuit related in any way to this injury/illness? ☐ YES ☐ NO

Have you received any settlement, payment, recovery of benefits, including insurance company policy, related in any way to this injury/illness? ☐ YES ☐ NO

Have you hired an attorney to represent you regarding this claim? ☐ YES ☐ NO

I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physcian to release information concerning my enrollment, related records and medical records to the Construction Industry Laborers Welfare Fund.

Insured Member's Signature _____ Date _____

INSTRUCTIONS:

DISABILITY

To collect disability benefits, your physician must complete questions, 1-6 and sign and date this form.

ATTENDING PHYSICIAN'S STATEMENT:

1. Date symptoms first appeared or accident happened.	2. Date patient first consulted you for this condition.	3. Has patient ever had same or similar condition? if yes, when and describe. ☐ YES ☐ NO
4. Is patient still under your care for this condition? ☐ YES ☐ NO	5. Patient was continuously disabled (unable to work). From: Thru:	6. Date patient should be able to return to work.

Print Physician's Name	Physician's Signature	Degree	Date
Street address		Telephone	
City	State	Zip Code	