



Chicago & Vicinity Laborers' District Council

Health & Welfare Fund • Retiree Health & Welfare Fund

LiUNA!

Feel the Power

11465 W. Cermak Road, Westchester, IL 60154-5768 | www.chicagolaborersfunds.com

Toll Free: (866) 906-0200 • Telephone: (708) 562-0200 7) 562-0716 - | | hlp .com

.....TGVKTGF'RCTVIEIRCPV'CEEH'GPV'ENCKO'HQTO

Failure to complete this form in full may result in delay of payment of your claims.

PARTICIPANT INFORMATION

Participant's Name: _____ Participant's Alt. ID: _____

Home Address: _____

Employer: _____ Rj ope: * ____ + _____

Date of Birth: _____ O are _____ Heo are _____

Employer's Name and Address: _____

City, State, Zip Code: _____ Date Employed: _____

INFORMATION ABOUT YOUR ACCIDENT CLAIM

Diagnosis: (free form for diagnosis) _____

Date of Claim: _____

Is this illness/injury due to an accident? Yes No (If yes, please provide details below)

Date of Accident: aaaaaaaaaaaaaa Where did accident occur? aa_aaaaaaaaaaaaaaaaaaaaaaaaaaaaaa_aaaaaaaaaa

Provide a description of how the injury/illness occurred and include a list of your injuries/disabilities:

Is the illness/injury work related? Yes No

If yes, have you filed or do you intend to file a Workers' Compensation Claim? Yes No

Who was the party responsible for the accident?

Name: _____ " Rj ope: * ____ + _____

City, State, Zip Code: _____

Do you plan to seek reimbursement from the other party? Yes No

Do you have or intend to hire an attorney for this accident? Yes No

If yes, please provide your attorney's name, address, and phone number:

If no, please be advised that you are required to notify the Fund Office should you hire an attorney in the future.

The above answers are true and correct to the best of my knowledge:

Participant's Signature: aa Date: aaaaaaaaaaaaaaaaaaaaaa

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result from such an act.