LABORERS' WELFARE FUND

LABORERS' HEALTH AND WELFARE DEPARTMENT OF THE CONSTRUCTION
AND GENERAL LABORERS' DISTRICT COUNCIL OF CHICAGO AND VICINITY
11465 WEST CERMAK ROAD
WESTCHESTER IL 60154
708-562-0200

DEPENDENT ACCIDENT CLAIM FORM

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

EMPLOYEE/DEPENDENT INFORMATION:

Employee's Name: _____ Social Security Number: _____

Home Address: _____

City, State, Zip Code: _____ Phone: (____) _____

Dependent's Name: _____ Social Security Number: _____

Dependent's Date of Birth: _____ Date of Claim: _____ Gender: Male ☐ Female ☐

CLAIM/ACCIDENT INFORMATION:

Describe the injury/reason for the doctor visit: _____

_____

_____

Date of Accident: _____ Time of Accident: _____

Where did accident occur? _____

_____

If the accident occurred at school, please complete the following:

School Name: _____

School Address/City: _____

Contact Name: _____ Phone: (____) _____

Was another party involved in the accident? Yes ☐ No ☐

Name: _____ Phone: (___) _____

Address: _____

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

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

Claimant's Signature: _____ Date: _____
(Parent or legal guardian if claimant is a minor)

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 act.