ACCIDENT REPORT
NECA-IBEW LOCAL 480 HEALTH AND WELFARE

Answer all questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

EMPLOYEES FULL NAME:_____SEX_____

HOME ADDRESS:_____

CITY:_____ST_____ZIP_____

HOME TELEPHONE NUMBER_____OTHER_____

SSN:_____ DOB_____

EMPLOYEE'S _____SINGLE ____MARRIED_____DIVORCED_____WIDOW_____SEPARATED.

EMPLOYED BY:_____
DATE OF
EMPLOYEMENT_____OCCUPATION_____
CLAIM IS MADE FOR:_____SELF_____SPOUSE_____CHILD

NAME OF DISABLE PERSON SEX DOB

DATE ACCIDENT OCCURRED_____TIME_____

WAS CLAIMANT AT WORK WHEN ACCIDENT OCCURRED:_____YES_____NO
NAME OF CLAIMANT'S EMPLOYER:_____
DETAILED DESCRIPTION OF ACCIDENT (if needed, use reverse side and tell **how, when and where** it occurred)

TYPE OF INSURANCE HELD BY OTHER PARTY:HOME_____AUTO_____
YOUR INSURANCE CARRIER:HOME_____AUTO_____
OTHER PARTY LIABILITY INSURANCE CARRIER_____
HAVE YOU HIRED AN ATTORNEY TO REPRESENT YOU IN THIS MATTER?
_____YES_____NO
IF YES, ATTORNEY'S NAME_____

ADDRESS_____

CITY/STATE/ZIP_____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete.

DATE CLAIM SIGNED:_____LOCAL UNION NO._____

SIGNATURE SSN