

Welfare Fund Benefits Office

United Food & Commercial Workers Local 655
13537 Barrett Parkway Drive, Suite 100
Manchester, Missouri 63021
(314) 835-2700 • Toll-Free (866) 565-2700 • Fax (314) 966-9848

To Whom It May Concern:

This accident/injury questionnaire is being sent to you because we have recently received a claim, and we are in need of additional information before we can process the claim. The claim was received with a diagnosis that could be related to an injury or accident. For our records, please complete the following questions to the best of your knowledge. Only one questionnaire needs to be completed per accident/injury. If there was not an accident or injury, please describe in the additional comments below. Upon receipt of the information below, your claim will be processed or, The Fund may request additional information.

Member Name: _____ Member ID # or SS#: _____

Patient's Name: _____ Patient's Date of Birth: _____

When did the injury/accident occur? _____

Where did the injury/accident occur? _____

How did the injury/accident happen? _____

Was this injury/accident caused by anyone other than yourself? • Yes • No

Is the treatment for this injury/accident covered under any Third Party Liability Insurance? • Yes • No

Was this injury/accident a result of a Motor Vehicle Accident? • Yes • No

Did this injury/accident happen/or is related to your work: • Yes • No

Additional Comments: _____

Certification

To the best of my knowledge and belief, the information provided above is true and accurate.

X _____

Signature of Patient (or parent/guardian if patient is under the age of 18)

Date

Your prompt attention to this matter is greatly appreciated. Please call the fund office if you have any questions.

Sincerely,
Local 655 Welfare Fund
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