

Heat & Frost Insulators Local 17 Benefit Funds

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Member's Policy ID Number:

Date of Service Information is requested: (on or around):

Information is requested for treatment of:

TO BE COMPLETED BY COVERED MEMBER

Please answer all of the questions. Unanswered questions will delay consideration until the Fund Office receives the missing information.

Member's Full Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone Number: _____

Date of Birth: _____

Claim is made for: _____ Self _____ Spouse _____ Child _____

Name of Injured Person ("Claimant"): _____

Was the injury a result of an accident: _____ YES** _____ NO

If yes, please answer questions below:

Was Claimant at work when accident occurred? _____ YES** _____ NO

Name of Claimant's Employer: _____

Was the injury a result of an accident caused by a third party? _____ YES** _____ NO

Describe briefly how the injury happened:

Please sign and date form:

Signature of Member or Adult Claimant

(PLEASE SEE OTHER SIDE)

WEBPAGE

If injury was a result of an accident, please complete all questions:

Date of accident: _____ Time: _____

Type of accident: _____ Automobile _____ Work _____ Other

Type of insurance: _____ Home _____ Auto _____ Workers' Compensation _____ Other

(Please submit any accident reports to the Fund Office)

Your Liability Insurance Information

Carrier: _____ Policy #: _____

Claim Number: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Telephone Number: _____

Other Party's Liability Insurance

Carrier: _____ Policy #: _____

Claim Number: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Telephone Number: _____

Have you hired an attorney to represent you in this matter? _____ Yes _____ No

If yes, please complete the questions listed below:

Attorney's Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Telephone Number: _____

Case Name: _____ Case Number: _____

Status of Case: _____

Settlement, if any: _____

If you have lost time from work, are you claiming disability benefits? _____ Yes _____ No

Please provide a brief description of the accident:

WEBPAGE