



Automobile Mechanics'  
Local #701 Welfare Fund

# Accident Form

<b>Section 1: Participant</b> – please provide the information requested below about the Participant.		
Name:		Date of Birth:
Group #:		ID #:
Home Address:		
City:	State:	Zip Code:
Phone:	Email:	

<b>Section 2: Claim Information</b> – please provide the information requested below about the claim.		
Name of Injured:	Relationship:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Home Address:		
City:	State:	Zip Code:
Phone:	Email:	
Date of Injury:	Location of Injury (City, State):	
Type of Accident:	<input type="checkbox"/> Automobile <input type="checkbox"/> Work <input type="checkbox"/> Other	
Describe the Injury & how it happened:		
Was a police report filed?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
* If yes, you must submit a copy of the police report.		
Was the Injury caused by a Third Party?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Section 3: Insurance</b> – please provide the requested insurance information below.	
Third-Party's Name:	Third-Party's Insurance Company Name:
Type of Insurance:	<input type="checkbox"/> Home <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other
Policy #:	Claim #:
Claims Representative:	Phone/Email:
Policy Limits:	
Claimant's Insurance Company Name:	
Type of Insurance:	<input type="checkbox"/> Home <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other
Policy #:	Claim #:
Claims Representative:	Phone/Email:
Policy Limits:	

<b>Section 4: Work-Related Claim</b> – only complete if the claim is work-related.	
Claimant's Employer at time of Injury:	
Employer Insurance Company:	
Policy #:	Claim #:
Claims Representative:	Phone/Email:

<b>Section 5: Attorney Information</b> – <i>only complete if an Attorney is representing you in this matter.</i>		
<b>Attorney Name:</b>	<b>Law Firm:</b>	
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>Email:</b>	
<b>Case #:</b>	<b>Case Name:</b>	
<b>State and County where Case Filed:</b>		

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to refusal of this claim. I further understand that I have completed and signed this form on behalf of myself and/or my dependents.

I hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, physician, clinic, pharmacy, or any other organization to release all information to Southwest Service Administrators ("SSA") or any independent audit firm with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any plan providing benefits or services. In addition, I authorize SSA's designated representative to release any benefit related information necessary to allow the Plan to recover any payments from any first and/or third-party source. I recognize that the self-funded Plan which I participate in has a Subrogation and Reimbursement Provision. By accepting benefits and signing below, I acknowledge my obligations, and that of my covered dependents, regarding this provision and agree to comply with the corresponding wording/provisions in the Summary Plan Description and Plan Document.

**Claimant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*if Claimant is a Minor*

In order for us to properly complete the processing of your claim, we need your response immediately. This form must be fully completed and unaltered to be accepted by the Plan.

**Please return this form and cover letter to:**

Southwest Service Administrators  
 P.O. Box 43110  
 Phoenix, AZ 85080-3110  
 Upload to Portal at [www.ssatpa.com](http://www.ssatpa.com)  
 Email: [701claim@mech701-benefits.org](mailto:701claim@mech701-benefits.org)

\*\* If you elect to submit any documents or other information via email to the Welfare Fund, we encourage you to use encryption or another secure method. \*\*