



Automobile Mechanics'

Local #701

Accident Form

1. Please provide the information requested below about yourself

Name:		Date of Birth:
Home Address:		
City:	State:	Zip Code:
Phone:	Email:	
Group #:		ID #:
Relationship to Participant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Dependent		

2. Please provide the information requested below about the Participant (if other than yourself)

Name:		Date of Birth:
Home Address:		
City:	State:	Zip Code:
Phone:	Email:	
Group #:		ID #:

3. Please provide the following information about the Accident

Date of the Accident:		
Location of the Accident (City and State):		
Type of Accident:	<input type="checkbox"/> Automobile	<input type="checkbox"/> Work <input type="checkbox"/> Other
Was a police report filed?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
<i>* If yes, you must submit a copy of the police report.</i>		

4. Did the Accident occur while you were at work? Yes No

If you responded "yes" to this question, please provide the following information:

Your Employer's Name:		
Employer Contact:		
Address:		
City:	State:	Zip Code:
Phone:	Email:	

5. Please briefly describe the circumstances surrounding the Accident:

--

6. Was a Third Party responsible for the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If you responded "yes" to this question, please provide the following information:		
Third-Party's Name:		Date of Birth:
Home Address:		
City:	State:	Zip Code:
Phone:	Email:	
Third-Party's Insurance Company:		
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:	
Policy Limits:		
Third-Party Attorney Name:		Law Firm:
Address:		
City:	State:	Zip Code:
Phone:	Email:	

7. Do you have insurance that may insure a part or all of the losses you sustained as a result of the Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If you responded "yes" to this question, please provide the following information:		
Insurance Company:		
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:	
Policy Limits:		

If you responded "no" to question nos. 6 and 7: please sign and date this questionnaire in the area provided below and return to our office, you do not need to complete page 3 of this questionnaire.

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 dependents.

Participant Signature: _____ **Date:** _____

Dependent Signature (if applicable): _____ **Date:** _____

Parent or Legal Guardian, if Dependent is a Minor: _____

Date: _____

8. Have you retained an attorney to assist you in recovering part or all of the losses you sustained as a result of the Accident? Yes No
If you responded "yes" to this question, please provide the following information:

Attorney Name:		Law Firm:
Address:		
City:	State:	Zip Code:
Phone:	Email:	

9. Have you or your attorney filed a lawsuit against the person or entity that may be responsible for the Accident? Yes No
If you responded "yes" to this question, please provide the following information:

State and County where Case Filed:	
Case Name:	
Case #:	Year Filed:
Case Status / Settlement (if any):	

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 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 PBA 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 PBA'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, in regards to this provision and agree to comply with the corresponding wording/provisions in the Summary Plan Description and Plan Document.

Participant Signature: _____ **Date:** _____

Dependent Signature (if applicable): _____ **Date:** _____

Parent or Legal Guardian, if Dependent is a Minor: _____

Date: _____

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:

Professional Benefit Administrators, Inc.
 PO Box 4687
 Oak Brook, IL 60522-4687
 Fax: (630) 286-4678
 Email: 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.****