Automobile Mechanics'
Local #701 Welfare Fund

Accident Form

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

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

Section 3: Insurance – *please provide the requested insurance information below.*	
Third-Party's Name:	**Third-Party's Insurance Company Name:**
Type of Insurance: ☐ Home ☐ Auto ☐ Worker's Comp ☐ Other	
Policy #:	**Claim #:**
Claims Representative:	**Phone/Email:**
Policy Limits:	
Claimant's Insurance Company Name:	
Type of Insurance: ☐ Home ☐ Auto ☐ Worker's Comp ☐ Other	
Policy #:	**Claim #:**
Claims Representative:	**Phone/Email:**
Policy Limits:	

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

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

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 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, 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:

Professional Benefit Administrators
P.O. Box 4687
Oak Brook, IL 60522
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. **