UFCW LOCAL 655
WELFARE FUND
13537 Barrett Parkway Drive suite 100
Manchester, Missouri 63021
phone | 314.835.2700 or 1.866.565.2700
Fax | 314.966.9848

Accident Questionnaire

To Whom It May Concern:

We have recently received a claim with a diagnosis that could be related to an injury or accident and are in need of additional information before we can process the claim. 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.

Patient Information

Member's Name	Social Security or ID #
Patient's Name	Member's Phone #
Member's Address	Claim #

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 at work? ○ Yes ○ No

Is this injury/accident work related? ○ Yes ○ No

Additional Comments: _____

Certification

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

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

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

Sincerely,
UFCW Local 655 Welfare Fund