Greater Kansas City Laborers Welfare Fund

6405 Metcalf Avenue, Suite 200 • Overland Park, KS 66202
Phone: (913) 236-5490 • Fax: (913) 236-5499

ACCIDENTAL INJURY QUESTIONNAIRE

Participant's Name: _____ SSN: _____

Patient's Name: _____ Relationship: _____

Provider(s) of Service: _____

Date(s) of Service: _____

Type of Injury: _____

Additional information is needed regarding this claim. Please complete this questionnaire and return it to the Fund Office in the enclosed envelope.

When did the accident occur? Date: _____ Time: _____

Exactly where did the accident happen: _____

Did the accident occur at work? ☐ YES ☐ NO

If YES, was a Workers Compensation Claim filed? ☐ YES ☐ NO

Was an Accident Report filed? ☐ YES ☐ NO

If YES, Police Department/Highway Patrol/Sheriff: _____

Accident Report Number: _____

How did the accident happen?:

_____

_____

_____

_____

_____

Please indicate the name and phone number of a family member that can be contacted between 8:30 am and 4:30 pm if additional information is needed regarding this claim:

Name of Contact Person: _____ Daytime Phone Number: _____

Participant's Signature: _____ Date: _____

Return this completed form to the Fund Office in the enclosed envelope.