Initial Accident – Injury – Illness
Questionnaire

Mail to: Municipal Health Benefit Fund
PO Box 188
North Little Rock, Ar. 72115
(501) 978-6137 (phone)
(501) 537-7252 (fax)

This Form must be filled out completely by the Member/Employee and returned before claims can be considered for processing. Thank you.

Member Name: ________________________________Member Telephone #:_________________

Member ID#: ___________________Member Date of birth: ___________________

Member Address: ____

City, State & Zip: ______________________________/___________________/___________________

1. This claim is being made for: ___self ___spouse___dependent

2. Name:____date of birth_____________________

3. Is this claim due to an accident/injury?____If **yes**, please complete the following: If **no,** go to # 7

   a. Date of Accident/Injury:____

   b. Location of Accident/Injury:____

   c. Owner of Property/Business/Other:____

   d. Owner's/Business/Other Address:____

   e. Owner's/Business/Other Telephone#:____

   f. Name of Homeowner policy/Liability Insurance:__________________________________

   g. Homeowner/Liability policy #:_____________________________/Phone________________

   h. Has claim been filed ____yes, ____no Claim#:_________________________________

Please describe accident/injury in detail:____

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4. Is this claim the result of a work related illness or injury?______If **yes**, list below:

YOU MUST FILE WITH YOUR WORKER COMP CARRIER FIRST: **Claim filed ___yes____no**

Workers Comp. Carrier:___________________________________/phone#:___________________

Address:____

Claim #:____

5. Do you own your own business?_________ Type of business:_______________________________
Do you work part or full time with another employer?_____If yes, please fill out the following:

Employer:____________________________________/Type of business_______________________

Address/Phone #:____/__________________
Is this claim the result of accident/injury relating to your business or other employer?___yes___no

6. Is this claim the result of an MVA? ______If yes, list below: **YOU MUST FILE WITH AUTO INS. FIRST.**

Police report made?_____yes or ___no **PLEASE ATTACH A COPY OF THE POLICE REPORT**.

Single vehicle: ___ At fault: ___ Third party at fault:___ Claim filed with auto ins. ___yes__no.

Auto Insurance Carrier:_____________________________________/Phone#:________________

Address:____/Policy #:________________________

Claim#:__________________________________ **PLEASE ATTACH A COPY OF YOUR INS. POLICY.**

Third Party Auto Insurance Carrier:____________________________/phone#:_________________

Policy Holder:____phone#:____________________

Policy Holder Address:____

Policy #:_____________________________________/Claim#:________________________________

7. If not due to an accident, please complete the following: **describe your pain and what hurts (exp. Back/Knee/Arm etc.) Date symptoms began**:_____________/_______________

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Member/Employee Signature and Date:____/___________

By signing above, I hereby present this claim and authorize any individual and/or organization to release information required for its acceptance. This form can't be accepted without your written signature.

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