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 before claims can be considered for processing. Thank you.

Member Name: _____ Member Telephone #: _____

Member ID#: _____ Member Date of Birth: _____

Member Address: _____

City & State: _____

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 in detail:

   _____
   _____
   _____
   _____

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

   <u>You must file with your Workers Compensation Carrier first</u>: 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 Motor Vehicle Accident? ☐ yes or ☐ no. **<u>You must file with auto ins. first</u>.**

   If **yes**, list below:

   Police report made? ☐ yes or ☐ no. **<u>Please attach a copy of the police report</u>.**

   Single vehicle: ____ At fault: _____ Third party at fault: _____ Claim filed with auto ins. ☐ yes or ☐ no.

   Auto Insurance Carrier: _____ phone#: _____

   Address: _____ Policy #: _____

   Claim#: _____ **<u>Please attach a copy of ins. policy</u>.**

   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 (example: Back/Knee/Arm etc.)

   _____

   _____

   _____

   _____

   Date symptoms began: _____

Member/Employee Signature: _____ **Date:** _____

By signing above, I hereby present this claim and authorize any individual and/or organization to release informa-tion required for its acceptance. This form can not be accepted with out your written signature.

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