

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:

You must file with your Workers Compensation 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 Motor Vehicle Accident? ___ yes or ___no. **You must file with auto ins. first.**

If **yes**, list below:

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 or ___no.

Auto Insurance Carrier: _____ phone#: _____

Address: _____ Policy #: _____

Claim#: _____ **Please attach a copy of 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 (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 information required for its acceptance. **This form can not be accepted with out your written signature.**