Initial Accident – Injury – Illness Questionnaire

Mail to: Municipal Health Benefit Fund
PO Box 188
North Little Rock, AR 72115

Phone: (501) 978 6137
Fax: (501) 537 7252

This form MUST be filled out completely by the Member/Employee and returned before claims can be considered for processing. Failure to complete this form may cause your claims to be denied.

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/incident? _____ please complete the following.
    a. Date of accident/injury/incident: _____
    b. Location of accident/injury/incident: _____
    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/incident in detail _____

_____

_____

_____

_____

_____

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

   Worker's Comp Carrier: _____ Telephone #: _____

   Address: _____

   Claim #: _____

5. Do you own you 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: _____ Telephone #: _____

   If 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, complete below: **YOU MUST FILE WITH AUTO INS FIRST**

   Police report made? ◯ yes ◯ no **PLEASE ATTACH A COPY OF THE POLICE REPORT**

   Single vehicle: _____ At fault: ____ Third party at fault: ____ Claims filed with auto ins ◯ yes ◯ no

   Auto Insurance Carrier: _____ Telephone #: _____

   Address: _____ Policy #: _____

   Claim #: _____ **PLEASE ATTACH A COPY OF YOUR INSURANCE POLICY**

   Third Party Auto Insurance Carrier: _____ Telephone #: _____

   Policy Holder: _____ Telephone #: _____

   Policy Holder Address: _____

   Policy #: _____ Claim #: _____

   Member/Employee Signature: _____ Date: _____

By signing above, I hearby present this claim and authorize any individual and/or organization to release information required for its acceptance.

Rev. 5/2018

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