Insured:_____

Patient:_____

MASONRY WELFARE TRUST FUND
9848 E BURNSIDE
PORTLAND OR 97216
(503) 254-4022
1-800-591-8326
FAX (503) 254-4119

REPORT OF ACCIDENT OR INJURY (The provider did not include this information on the bill)

PATIENT NAME:_____
SUBSCRIBER NUMBER:_____ PATIENT BIRTHDATE:_____
DATE OF INJURY/ACCIDENT:_____

IS THE INJURY OR ACCIDENT EMPLOYMENT RELATED? YES_____ NO_____

PLEASE DESCRIBE HOW AND WHERE THIS INJURY/ACCIDENT OCCURRED:
_____
_____
_____

DID THE ACCIDENT OCCUR AT A COMMERCIAL/PUBLIC PLACE? YES?_____ NO?_____

DO YOU INTEND TO SEEK RECOVERY FROM THAT PARTY? YES?_____ NO?_____

DID THE ACCIDENT OCCUR AT YOUR HOME/PROPERTY? YES?_____NO?_____

DID THE ACCIDENT OCCUR ON SOMEONE ELSE'S PROPERTY? YES?_____ NO?_____

IS THERE HOMEOWNER'S INSURANCE TO COVER COSTS? YES?_____ NO?_____

DO THE OWNERS HAVE INSURANCE TO COVER MEDICAL COSTS? YES?_____ NO?_____

DO YOU INTEND TO SEEK RECOVERY FROM THAT PARTY? YES?_____ NO?_____

DID SOMEONE ELSE CAUSE YOU TO HAVE THIS INJURY? YES?_____ NO?_____

IS THIS INJURY OR ACCIDENT VEHICLE RELATED? YES?_____ NO?_____

- If yes on vehicle related, please submit to your auto insurance

OTHER COMMENTS:_____
_____
_____

I agree that the above information is complete and correct. I understand that I will be responsible to reimburse the Masonry Welfare Trust Fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form or if I conceal any information pertaining to any such claims.

SIGNATURE:_____PHONE#:_____DATE:_____