MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
14 NEW ENGLAND EXECUTIVE PARK, SUITE 200
BURLINGTON, MASSACHUSETTS 01803-5201
TELEPHONE: (781) 272-1000 or (800) 342-3792 FAX: (781) 238-0703

MEMBER INFORMATION

Member Name: _____ MLBF ID#: _____

Patient: _____ D.O.B. _____

Phone # where you may be reached: _____

Address: _____

_____

ALL INFORMATION IS REQUIRED IN ORDER FOR CLAIMS TO BE PROCESSED OR FORM WILL BE RETURNED.

Dear Member, Was your injury a result of:

1) **Motor Vehicle Accident?** Yes ___ No ___
If yes, List any other injured family members _____

Employment? Yes ___ No ___
If yes, did you report it to your employer? Yes ___ No ___

Other? Please Circle: Slip & Fall, Assault, Dog bite, Public place or event, School activity, Vacation, Rental property, Etc.

2) If this claim is ***not*** due to any of the above, please explain why you needed this procedure? _____

_____

_____

3) **Please provide Claim Number**(s) or Dates of Service _____
(***or*** include a copy of your EOB) _____

4) **HOW** did this injury occur? Explain/details: _____

_____

_____

_____

5) **WHEN** did this injury occur? **DATE**: _____

Continue on other side

6) **WHERE** did this injury occur? _____

_____

PLACE _____

7) **WHAT** are your injuries? _____

_____

8) Have you or do you plan to retain an Attorney to file a claim against another party involved in this injury? Yes _____ No _____

If YES, please provide Name, Address & Phone # of your Attorney:

_____

_____

9) Has this case already been settled? Yes _____ No _____
I f Yes, When _____

* **If you decide to pursue legal action, you <u>MUST</u> notify The Fund immediately or your benefits may be denied.**

The information provided on this form is true and complete to the best of my knowledge.

Signature of:

Member: _____ Date: _____

Patient: _____ Date: _____

Please mail or fax this form to the address above Attention: CLAIMS DEPT. so that your claims can be processed in a timely manner.

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