



Electrical Welfare Trust Fund • Electrical Workers Local No. 26 Pension Trust Fund • Electrical Workers Local No. 26 Individual Account Plan • Local Labor Management Cooperation Committee

Statement of Injury

We have received a request to verify benefits or have received a claim that included information suggesting that the service rendered **MAY** be the result of an injury or an accident. **Please complete this form explaining how the injury occurred and the other information requested in the spaces provided.** This form will provide Electrical Welfare Trust Fund with information concerning anyone else involved in this accident, any insurance coverage available and any police reports that may have been filed.

Completing & returning this form now may prevent EWTF from denying your claims. Every box must be completed. A return envelope is enclosed for your convenience.

You may be completing this form due to injury(ies) sustained as the result of the following: (check any and all that may apply)

Section 1

<input type="checkbox"/> Automobile Accident	<input type="checkbox"/> Motorcycle Accident	<input type="checkbox"/> 4 Wheeler Off Road Vehicle Accident	<input type="checkbox"/> Assault
<input type="checkbox"/> Job Related Accident	<input type="checkbox"/> Mishap at Home	<input type="checkbox"/> Mishap at Someone Else's Home	<input type="checkbox"/> Other, please be specific:
<input type="checkbox"/> Sports Related Injury	<input type="checkbox"/> Accident in Public Building	<input type="checkbox"/> Accident in Retail Store	

Section 2

Employee's Name	Employee's SSN	Email Address
Street Address	City/State	Zip Code
Name of Injured Persons	Relationship to Employee	Date of Injury/Accident/Illness:

Section 3

Location of the accident or where the injury occurred (provide complete address/explain if different than address above)	Was a police report filed? YES (attach copy of report) NO
<p>* Describe the accident or how the injury occurred fully. (Attach a separate sheet of paper if necessary).</p> <p>Injuries include, but not limited to the following: bump/bruise, sprain/strain, fracture, burn, cut/scrape, cut/open wound, contusion, concussion, backache, headache, neck pain, joint pain, knee pain, foot/ankle pain, animal/insect bite.</p> <p>◆ If your pain is not related to any accident or injury, please indicate how pain started (<i>i.e. exercising, sports/age related, woke up with pain.</i>)</p>	

Section 3 (continued)

List any other individuals involved	Name of their insurance company	Insurance company telephone number
<p>Circle any/all that may apply:</p>		
<p>Is your motorcycle insured? YES or NO Motor Vehicle Accident: Was one vehicle involved? YES or NO If more than one vehicle was involved, how many vehicles involved? _____</p>		
<p>Have you filed a claim with Worker's Compensation? YES or NO</p>		
<p>If assaulted, did you know the assailant? YES or NO Are you filing charges: YES or NO</p>		
<p>Was the accident in someone else's home? YES or NO Are you filing with Homeowners Insurance YES or NO</p>		
<p>Name & address of your insurance company</p>		
<p>Will medical expenses be provided by anyone (an insurance company or individual) other than you?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> Yes – List Names _____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p>		

NOTE: BENEFITS ARE NOT PAYABLE FOR WORK-RELATED INJURIES OR FOR INJURIES THAT ARE CAUSED BY A THIRD-PARTY SUCH AS ANOTHER MOTORIST.

The rules of this plan provide that the responsible third party, or the injured person's private insurance, such as homeowners or motor vehicle insurance, be primarily responsible for payment for medical expenses and lost time. This plan will "advance" or "loan" benefits to pay bills as they come in. Any "advances" or "loan" of benefits is to be repaid to EWTF once the third party, whether an individual, employer, or insurance company has made payment. **To secure such repayment EWTF requires that the individual and their attorney, if any, signs a promissory note and repayment agreement before benefits are advanced.**

I hereby certify that these statements are complete and true.

Signature _____ **Date** _____

Notarization is required for automobile accidents and Workers Compensation. Notarization may be required for other third party accidents.

County of: _____ State of: _____

On this ____ day of _____, _____, personally appeared before me _____

who, being duly sworn, subscribed to the foregoing in my presence.

Notary Public _____ **seal**