Mo-Kan Sheet Metal Workers Welfare Fund
Accident Questionnaire

Member Name:
Claim ID:
Member ID:
Group ID: 85000000
Date of Service:

1. Was the injury due to an accident? Yes ☐ No ☐
   If yes, how did the accident occur?
   _____
   _____
   Place of Accident:_____ Date of Accident:_____
2. If the injury was caused by the negligence or wrongful conduct of another person or company, please complete the following:
   Party at fault:_____
   Address:_____
   Party's Insurance Company and Address:_____
   _____
   Claim Adjuster Name:_____
   Phone Number:_____
   Policy/Claim Number:_____
3. Have you made a claim against the party at fault? Yes ☐ No ☐
4. Do you intent to make a claim? Yes ☐ No ☐
5. Have you hired an attorney to represent you? Yes ☐ No ☐
   Name of firm:_____
   Attorney's Name:_____
   Address:_____
   Phone Number:_____
6. Was the injury/illness work related? Yes ☐ No ☐
7. Do you have worker's compensation insurance? Yes ☐ No ☐
   If yes, what is the carrier's name and address:_____
   _____
8. Was the injury due to an auto accident? Yes ☐ No ☐
9. If yes, in what state did the accident occur?_____
10. What is the accident date?_____
11. Please list the name of any family members injured in this accident:_____
    _____
12. Do you have automobile coverage through a group plan? Yes ☐ No ☐
13. Do you have personal injury protection? Yes ☐ No ☐
14. What is the name and address of your auto insurance carrier?_____
    _____
    _____

_____
Signature of Policyholder Current Telephone Number Date

Please return to: Mo-Kan Sheet Metal Workers Welfare Fund, PO Box 300019, Kansas City, MO 64130-0019