

# ***Laborers' Metropolitan Detroit Health Care Fund***

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## **ACCIDENTAL INJURY QUESTIONNAIRE**

Participant's Name \_\_\_\_\_ SS# \_\_\_\_\_

Patient's Name/Relationship \_\_\_\_\_

Provider(s) of Service \_\_\_\_\_

Date(s) of Service \_\_\_\_\_

Type of Injury \_\_\_\_\_

Additional information is needed regarding this claim. Please complete this questionnaire and return it in the enclosed envelope.

When did the accident happen? \_\_\_\_\_

**(Please give date and approximate time of accident)**

Exactly where did the accident happen? \_\_\_\_\_

Was the person hurt on the job? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, was a Worker's Compensation Claims filed? \_\_\_\_\_ Yes \_\_\_\_\_ No

How did the accident happen?

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**Please indicate the name and telephone number of a family member that can be contacted between 8:15 a.m. and 4:30 p.m., if more information is needed regarding this claim.**

\_\_\_\_\_  
Name of contact Person

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

