

Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds

Trustees:
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Injury Report

All questions must be completed by the Participant.

If any of the questions do not apply, please indicate so by answering with an N/A for not applicable.

Please complete the following questions if claim is due to an injury.

Member's name _____ ID or SSN# _____

Patient's name _____ Date injury occurred _____

Have you contacted your home/auto insurance company? Yes No

Name and Phone # of home/auto insurance company _____

Was patient at work when injury occurred? Yes No

If so, name of patient's employer _____

Please describe how, when and where injury occurred _____

Please complete the following questions if injury was the result of an automobile accident or other incident caused by a third party.

Please list name(s) of other party(ies) involved in the incident _____

Insurance company of other party _____

Policy #(s) _____ Type _____

Were police called? Yes No Was accident report completed by police? Yes No

If a report was completed, please attach a copy to this form.

Were charges lodged against you? Yes No

Were charges lodged against the other party? Yes No

Nature of charge _____

Have you hired an attorney to represent you in this matter? Yes No

If yes, attorney's name _____ Phone # _____

Address _____

Member's signature _____ Date _____