



LOCAL 36 BENEFIT FUNDS

2319 CHOUTEAU AVE., SUITE 300 · ST. LOUIS, MO 63103 · www.smw36benefits.org
Tel: (314) 652-8175 Toll-Free: (800) 741-9411 Fax: (314) 652-0338

Why do I need to complete an Accident/Injury Claim Form?

When you or someone in your family is seen by a doctor for a diagnosis that could be related to an injury, you will receive an Accident/Injury Claim Form in the mail. The form asks you to indicate what your injury or illness is, how the injury or illness occurred and where it occurred. Giving as much detail the first time you fill out the form will help us in processing your claims faster. These claims are in denied status even though the claims are pending additional information and once the information is received the claims will be paid and you will receive a new Explanation of Benefits.

In some cases, more information may be needed. For example, you were involved in a motor vehicle accident, injured your back and were seen at the emergency room. Once this claim is received, an Accident/Injury Claim Form will be sent. We will need to know if a third party was at fault and will need a copy of the police report along with a copy of your Auto Insurance Declaration Page.

We are a self-funded plan, which means claims are paid out of contributions received. We want to make sure we carefully spend your money so we can continue to provide you with the best benefits possible. Sometimes that may mean filing claims with third parties (i.e. an auto insurance company) who could be responsible to pay for those claims first. By giving us that information you are helping the Fund make sure that money is not being spent when it shouldn't be.

Here are some important things to remember when completing Accident/Injury Claim Forms:

- Give as much detail as possible
- Provide additional information as needed
- Claim forms are needed every 6 months for an ongoing illness or injury
- Signatures are required

If you have any questions regarding this form or any other forms, you can call us at 314-652-8175.



Accident/Injury Claim Form

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2319 CHOUTEAU AVENUE, STE. 300
ST. LOUIS, MO 63103

Member Name: _____ Member ID#: _____

Patient Name: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Please describe injury/illness: _____

Date of injury/illness: _____

Where did injury occur: _____

How did injury occur: _____

Is this injury/illness related to a MOTOR VEHICLE ACCIDENT? CIRCLE ONE: YES NO

If YES, please complete the info below. If NO, please skip to next section.

Auto Insurance Provider: _____ Contact: _____

Phone: _____ Policy#: _____ Claim#: _____

Is a THIRD PARTY responsible for your injury/illness? CIRCLE ONE: YES NO

If YES, please complete the info below. If NO, please skip to next section.

Responsible Third Party: _____ Third Party Phone#: _____

Third Party Insurance Provider: _____ Third Party Insurance Policy#: _____

Is injury/illness WORK RELATED? CIRCLE ONE: YES NO

Have you reported injury/illness to your employer? CIRCLE ONE: YES NO

Has an attorney been retained in relation to this injury/illness?: CIRCLE ONE: YES NO

Attorney Name: _____ Attorney Phone#: _____

Attorney Address: _____

Signature of Patient (or legal guardian if patient is under 18):

_____ Date: ___ / ___ / ___

Processor: _____

Date: ___ / ___ / ___