Insulators and Allied Workers National Medical Fund
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Administered by: NEBA

Accident/Injury Details Form

Dear Participant or Dependent:

The Fund Office has received a claim for you with a diagnosis that could be related to an injury. We need additional information about how your condition occurred before we can complete the processing of your claim.

A. Employee Information					
1.	**Employee Name:**		**4.**	**SSN (last 4 digits):**	
2.	**Date of Birth:**		**5.**	**Telephone Number:**	( ) -
3.	**Address:**				

B. Patient Information					
6.	**Patient Name:**		**10.**	**Does the Patient have other insurance? If yes, answer questions below.**	☐ Yes ☐ No
7.	**SSN (last 4 digits):**		Insurance Carrier Name:_____		
8.	**Date of Birth:**		Insurance Carrier Phone #: _____		
9.	**Relationship to Employee:**		Insured's Name: _____		
			Insured's ID or Policy #:_____		
			Insured's Group # _____		

C. Explanation of Symptoms / Condition Please answer all of the following questions relating to the condition reported on your claim. The questions should be answered by the patient or, if the patient is a minor child, the patient's parent/guardian.	
11.	When did you first experience the symptoms reported on your claim? If you are unsure, please estimate the date.

12.	Was there a specific incident that you believe caused your symptoms? For example, lifting a box, or an automobile accident?
13.	If there was a specific incident that you believe caused your symptoms, where did it occur?
14.	If there was a specific incident that you believe caused your symptoms, please describe the incident in detail below. _____ _____ _____ _____
15.	If there was no specific incident that caused your symptoms, please describe how the symptoms developed. _____ _____ _____ _____
16.	Are your symptoms related to your employment?

In certain cases, NEBA may determine that your claim could potentially be reimbursable by a third party that has financial responsibility (for example, if you are in an automobile accident and a third party is responsible for your medical bills). We may require that you complete the Fund's "Assignment, Subrogation and Restitution Agreement" before we can complete the processing of your claims. Once we review the details of how your condition occurred we will notify you if we need this additional document.

D. Signature

By signing below, I attest that the above answers are true and complete according to the best of my knowledge and belief. I acknowledge the subrogation right of the Plan and agree to repay any sums expended by the Plan for injury or sickness if I receive payment from another party or source.

Employee Signature:_____ Date: _____

Patient Signature:_____ Date: _____