

Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, Washington 98111-1929 (206) 441-6514 (800) 552-0635

Personal Injury Questionnaire

Important: Please complete and sign the *Personal Injury Questionnaire* and the *Reimbursement Agreement* and return them to the Trust Office. Separate forms are required for each injured person covered under the Carpenters Health and Security Plan.

1. Participant's name (please print): _____
2. Street address: _____
City, state, zip: _____
3. Telephone: () _____ Social Security number: _____
4. List the name and relationship of the covered family member injured. Separate forms are required if more than one covered family member was injured.
Name: _____ Relationship: _____
5. When did the injury occur? Date: _____ Time: _____
6. Where did the injury occur? _____

7. How did the injury occur? _____

8. Type of injury suffered: _____
9. Did this injury occur in the course of employment? Yes No
10. Was another party responsible for the injury? Yes No. If yes, please complete 10(a) through 10(e). If no, please skip to 11:
 - (a) Name of the party responsible: _____
 - (b) Name of the responsible party's insurance company: _____
 - (c) Address of the insurance company: _____
 - (d) City, state, zip: _____ Telephone number: () _____
 - (e) Policy number: _____
11. Have you or do you intend to submit a claim to your insurance company and/or the responsible party's insurance company? Yes No. If yes:
Which insurance company: _____
What is the claim number: _____
What is the name of the person handling the claim: _____

12. Have you or do you intend to hire an attorney to represent you in this matter? Yes No. If yes:

Name of your attorney: _____

Address of your attorney: _____

City, state, zip: _____ Telephone number: () _____

13. Has the injured party missed work as a result of your injury? Yes No. If yes, when:

From (specific date): _____ To (specific date): _____

14. Have you or the injured party received payments as a result of the injury from any source including insurance plans?

Yes No. If yes, from whom? _____

I hereby certify that the foregoing statements (including any accompanying statements) are true, correct and complete to the best of my knowledge. I understand I must also complete the *Reimbursement Agreement When Recovery Is Obtained Against A Third-Party or Insurer* and return it with this form to the Trust Office.

Injured Party's Signature

Date Signed

Signature of Legal Guardian of Minor Child (if applicable)

Date Signed