Carpenters Health and Security Plan of Western Washington

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

Motor Vehicle Accident Report

Important: Please complete and sign the ***Motor Vehicle Accident Report*** and the ***Reimbursement Agreement Form*** 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 in the accident. Separate forms are required if more than one covered family member was injured.

   Name: _____ Relationship: _____
5. When did the accident occur? Date: _____ Time: _____
6. Where did the accident occur (please attach a copy of the "police traffic collision report"? _____

   _____
7. How did the accident occur? _____

   _____

   _____
8. Type of injury suffered: _____
9. Did this accident occur in the course of employment? ☐ Yes ☐ No
10. What kind of accident was it? ☐ Car ☐ Motorcycle ☐ Other. If other, please specify: _____
11. What role did the injured party play? ☐ Driver ☐ Passenger ☐ Pedestrian
12. Was another party responsible for the accident? ☐ Yes ☐ No. If yes, please complete 12(a) and 12(b). If no, please complete 12(a) only:

    (a) Your Insurance Information

    Name of the insured: _____

    Name of the insurance company: _____

    Address of the insurance company: _____

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

    Policy number: _____ Claim number: _____

    Does the insurance policy have:

    Personal injury protection (PIP)? ☐ Yes ☐ No. If yes, please list the amount: $ _____

    _____

    Uninsured motorist protection? ☐ Yes ☐ No

    Underinsured motorist protection? ☐ Yes ☐ No

(b) Responsible Party's Insurance Information

Name of the driver: _____

Name of the driver's insurance company: _____

Address of the insurance company: _____

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

Policy number: _____

13. 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: _____

14. 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: ( ) _____

15. Have you missed work as a result of your injury? ☐ Yes ☐ No. If yes, when? _____

16. Have you and/or your dependents 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* form 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