**IBEW- NECA SOUTHWESTERN**
**HEALTH & BENEFIT FUND**
**PO BOX 819015**
**DALLAS, TX 75381-9015**

**MEMBER:**
**PATIENT:**
**ID:**
**DATE OF SERVICE :**
**BILLED AMOUNT:**
**DATE SENT:**

In order to process this claim we need accident/injury details.
Please complete the accident/injury questionnaire and return to the fund office.

If an accident was involved, when did it happen?
Is this injury work related? Yes _____ No _____
Where did the accident occur? _____
Give a brief description of how the injury occurred:
_____

_____

Did you file any other claims of legal action relating to this accident, including one against your own insurance company?
Yes____ No___
If yes, please indicate who the claim or action is against:
Name: _____

Insurance company, if applicable: _____

Is claim or suit: ONGOING _____ OR CLOSED _____
Attorney's name: _____
Phone # ( )_____
Address _____

If you have not yet filed a claim or suit, do you intend to file
Yes ____ No_____

Member Signature _____ Date _____

Please contact our Customer Service Department at 1(800) 527- 0320 or (972) 980-1123 with any questions.