

# Alaska United Food and Commercial Workers Trust Funds

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Administered by  
Welfare & Pension Administration Service, Inc.

Date:

Patient Name:  
Address:

Member Name:  
WPAS ID:

## 'IMMEDIATE ACTION IS REQUIRED'

We have received a claim for treatment on \_\_\_\_\_.

The condition being treated is a \_\_\_\_\_.

Since this condition could be injury related, we need you to please answer the following questions. **Your claim cannot be processed without this information. This information cannot be taken over the phone.**

A. Check which instance applies to the injury/condition:

- Motor vehicle accident  
 Work-related  
 Home-related  
 Product Liability                       Other \_\_\_\_\_

B. Is the condition/injury the result of practice for, travel to, or travel from intercollegiate competition as a team member, or participation in any intercollegiate, semiprofessional or professional sport.

- Yes                       No

C. Briefly describe how the injury happened: \_\_\_\_\_

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|  |

D. Give Date \_\_\_\_\_ and time \_\_\_\_\_ (AM \_\_\_ PM \_\_\_) of injury.

E. Name of person responsible for the injury? (If yourself, say so) \_\_\_\_\_

If you have received or expect to receive reimbursement from any insurance, excluding this coverage, please answer the following:

- F. Have you made a claim for reimbursement?                       Yes                       No  
If yes, have you received any restitution of settlement?                       Yes                       No  
If yes, when? (give date) \_\_\_\_\_.                      Amount of settlement was \$ \_\_\_\_\_  
Was it a final settlement?                       Yes                       No  
If you received some other type of restitution, please describe: \_\_\_\_\_

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G. Please complete the following:

1. Provide name and address of the insurance company of the party or person responsible for the accident:

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|  |

Agent Name \_\_\_\_\_ Phone No \_\_\_\_\_  
Insured party or person name \_\_\_\_\_

2. Name and address of your automobile, homeowners, or similar policy.

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|  |
|  |

Agent Name \_\_\_\_\_ Phone No \_\_\_\_\_  
Insurance Claim Number \_\_\_\_\_

3. Do you have Personal Injury Protection coverage on your automobile coverage?  Yes  No  
If yes: you need to file a claim with them.  
If no: **please provide us with a copy of the signed waiver or declaration page from your policy.**

4. If a motor vehicle accident, were you a passenger?  Yes  No  
If yes: please provide the Name and address of the automobile insurance that covers the driver of the car you were riding. \_\_\_\_\_

Agent Name \_\_\_\_\_ Phone No \_\_\_\_\_

5. Do they have Personal Injury Protection coverage on their automobile coverage?  Yes  No  
If yes: you need to file a claim with them.  
If no: please provide us with a copy of the signed waiver or declaration page from their policy.

6. Was a police report filed?  Yes  No **(If yes, please attach a copy to this form upon return.)**

H. If the condition was related to your employment, please indicate if you were:

1. Working for an employer. (If so, give name and address) \_\_\_\_\_

2.  Self-employed \_\_\_\_\_

3.  Working for any other person for wage or profit

Give name and address and explain. \_\_\_\_\_

I. If you have an attorney representing you in obtaining settlement or restitution in regards to this injury, however it occurred, please give:

Attorney Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_ Zip \_\_\_\_\_

The undersigned agrees to cooperate fully with the Plan in asserting its rights under this subrogation agreement and to supply the Plan with any and all information and execute any and all instruments that the Plan reasonably needs for that purpose.

I certify the foregoing statements are true, correct and complete. I further authorize the hospital, physician or other health provider to furnish and disclose to Welfare and Pension Administration Service any and all facts concerning my condition that are within their knowledge. A copy of this authorization is to be considered valid for that purpose.

Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(If not minor child)