

# Plumbers & Steamfitters Local 33 Health & Welfare Fund Office

2501 Bell Avenue  
Des Moines, IA 50321  
Telephone: 515-243-3246 (option 1)  
Fax: 515-244-6606

## INJURY QUESTIONNAIRE

Participant's Name \_\_\_\_\_ ID# \_\_\_\_\_

Patient's Name/Relationship \_\_\_\_\_

Provider(s) of Service \_\_\_\_\_

Date(s) of Service \_\_\_\_\_

Type of Injury \_\_\_\_\_

Additional information is needed regarding this claim. Please complete this questionnaire and return it in order to avoid further delay in the processing of this claim.

When did the injury happen? \_\_\_\_\_

**(Please give date and approximate time of injury)**

Exactly where did the injury occur? \_\_\_\_\_

Please describe how the injury happened?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there another party responsible for this injury (automobile, homeowners insurance)? \_\_\_ Yes \_\_\_ No

If yes, please give the name and contact information for the responsible party. \_\_\_\_\_

Did the injury occur on the job? \_\_\_ Yes \_\_\_ No

If yes, was a Worker's Compensation Claim filed? \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
**Participant's Signature**

\_\_\_\_\_  
**Date**