

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 _____

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

Have you served in the military? Yes No

Did this injury occur during your service? Yes No

Do you qualify for VA Health Care Benefits for this condition? Yes No

Participant's Signature

Date

I certify that the above information is true & correct. I hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish the Plumbers & Steamfitters Health & Welfare Fund with information regarding benefits to which I may be entitled. A copy of the authorization shall be considered as effective and valid as the original.