National Roofers Union
& Employers Joint
Health & Welfare Fund

Dear Participant:

We have received a claim that appears to be the result of an accident or an injury. We are unable to process the claim until the following information is received.

Patient Name: ______________________________ Patient Date of Birth: ____________________

1. Were the services provided related to an accident or an injury? ☐ Yes ☐ No
2. Date of Service: ____
3. Provider's Name: ____
4. When did the accident or injury occur? ______________________________
5. Where did the accident or injury occur? ______________________________
6. How did the accident or injury occur? ______________________________
7. Is the accident or injury the result of an auto accident? ☐ Yes ☐ No
8. Is the accident or injury related to any employment? ☐ Yes ☐ No
9. Have you or do you intend to file a liability claim or lawsuit? ☐ Yes ☐ No

   If yes, please provide the name, address and phone number of your attorney:

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I certify that the above information is true and correct.

Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Member ID: ____________________