

Pipe Fitters Local 597  
**WELFARE & RETIREMENT FUNDS**

Union Trustees  
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Employer Trustees  
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**ACCIDENT FORM**

Member's Name

\_\_\_\_\_  
First Middle Initial Last

\_\_\_\_\_  
Social Security Number Local 597 Union Card Number

Address

\_\_\_\_\_  
Street City State Zip Code

Phone Number

\_\_\_\_\_

E-Mail Address

\_\_\_\_\_

Patient's Name

\_\_\_\_\_  
First Middle Initial Last

Regarding:

\_\_\_\_\_

We need your help in supplying the following information before we can process the claim submitted.

Please explain why the patient sought medical attention.

Explanation: \_\_\_\_\_

Related to the Job: Yes  No

If this was an accident please supply us with the additional information.

How: \_\_\_\_\_

When: \_\_\_\_\_

Where: \_\_\_\_\_

Are you filing a medical claim against any Auto, Property/Casualty Insurance? Yes  No

If you have any questions, we will be pleased to answer them.

Member's Signature \_\_\_\_\_ Date / /