

NECA-IBEW WELFARE TRUST FUND

2120 Hubbard Avenue, Decatur, Illinois 62526

Phone: (217) 875-0254 or 800-765-4239

EMPLOYEE STATEMENT FOR ACCIDENT

Note to Employee: You must complete this side for any accident for your **spouse**.

1. Employee's social security no. _____

2. Employee's name: _____

3. Address: _____ City: _____ State: _____ Zip: _____

4. Birth date: _____ Sex: M F Local Union #: _____ Phone #: _____

5. Information on the person who claim is for:

| | | |
|-------|--------------------------|-------------|
| _____ | _____ | _____ |
| Name | Relationship to Employee | Soc. Sec. # |

| | |
|---------------|-------|
| _____ | _____ |
| Date of Birth | Sex |

6. Date of accident _____ Time _____ A.M. P.M.

Where did accident occur? _____

How did accident happen? _____

If your spouse is employed:

Was the injury caused by claimant's employment? Yes No

Has a claim been filed with Workman's Compensation? Yes No

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this accident. I will reimburse the Fund for any overpayment made to me or in my behalf due to error on this form.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Your Claim Cannot be Processed Without the Above Signatures