Northwest Laborers-Employers Health & Security Trust
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ACCIDENTAL INJURY/ILLNESS REPORT FORM

SECTION I: GENERAL INFORMATION

Participant Name: _____ ID#-TSTP: _____

Patient Name(s): _____ Date of Injury or Illness: _____

a) Was this injury or illness a result of an accident? YES ☐ NO ☐

b) Describe your injury or illness: _____

_____

c) How did this occur (slip, trip, fall, exposure, etc.): _____

d) Did another party (someone other than the participant or patient) cause the incident and/or be legally responsible to pay for any injuries/condition resulting from the incident: YES ☐ NO ☐

If you answered "NO" to question (d), please sign and return this form to the Trust office.

If you answered "YES" to question (d), PLEASE CONTINUE. Use the back of this form if you need additional space.

SECTION II: ACCIDENTAL INJURY/ILLNESS DETAILS

a) Where did the injury or illness occur: Work ☐ Home ☐ Public Property ☐ Other ☐
If other, please explain:_____

b) Was the incident investigated by the police: YES ☐ NO ☐
If "YES", are you able to provide a copy of the police report to the Trust Office if needed: YES ☐ NO ☐

c) Name of at-fault party (person, company, employer, other entity): _____

d) Name and phone number of at-fault party's liability insurance (if other party has no insurance, please write "No Insurance"): _____

e) Has claim/suit been filed against the at-fault party's liability insurance: YES ☐, Claim#:_____ NO ☐
What is the status of claim/suit: STILL OPEN ☐ CLOSED ☐ SETTLED ☐

f) Did your injury involve a motor vehicle: YES ☐ NO ☐

If you answered "NO" to question (f), please sign and return this form to the Trust office.

If you answered "YES" to question (f), PLEASE CONTINUE. Use the back of this form if you need additional space.

SECTION III: MOTOR VEHICLE INCIDENT DETAILS

a) Please check one. Were you a: Driver ☐ Passenger ☐ Pedestrian ☐

b) The owner of the vehicle: _____
Address: _____
The name of company which insured the vehicle you were in: _____

c) If you were a pedestrian ***or*** you were in a car that was struck by another vehicle, please indicate the following:
Name of the owner of the vehicle which struck you: _____
Address of the vehicle owner: _____
The name of the insurance company which insured that vehicle: _____

I hereby certify that the foregoing statements are true, correct and complete to the best of my knowledge. I hereby authorize my attending Physician, Hospital, the Department of Labor & Industries Project Help Program, Attorney office, or other insurance office to furnish and disclose any and all information requested by Zenith American Solutions. This information can include but is not limited to medical information, dates of examinations, consultations, x-ray reports, operative reports, hospital information, diagnosed conditions, prescriptions, treating information, Workers' Compensation/Labor & Industries claim information, or Third-Party Liability claim information. I understand I am releasing this information to my Trust Administrator. I understand these records will be treated confidentially in accordance with the Federal HIPPA regulations. I understand this authorization can be withdrawn at any time.

Participant Signature: _____ Date: _____

Patient Signature (if other than Member and over age 18): _____ Date: _____

Please provide a daytime phone number with area code in case we need to contact you or the patient:_____