

**MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND**

14 NEW ENGLAND EXECUTIVE PARK, SUITE 200  
BURLINGTON, MASSACHUSETTS 01803-5201  
TELEPHONE: (781) 272-1000 or (800) 342-3792 FAX: (781) 238-0703

**MEMBER INFORMATION**

Member Name: \_\_\_\_\_ MLBF ID#: \_\_\_\_\_

Patient: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Phone # where you may be reached: \_\_\_\_\_

Address: \_\_\_\_\_

**ALL INFORMATION IS REQUIRED IN ORDER FOR CLAIMS TO BE PROCESSED  
OR FORM WILL BE RETURNED.**

Dear Member, Was your injury a result of:

1) **Motor Vehicle Accident?** Yes \_\_\_ No \_\_\_  
If yes, List any other injured family members \_\_\_\_\_

**Employment?** Yes \_\_\_ No \_\_\_  
If yes, did you report it to your employer? Yes \_\_\_ No \_\_\_

**Other?** Please Circle: Slip & Fall, Assault, Dog bite, Public place or event,  
School activity, Vacation, Rental property, Etc.

2) If this claim is **not** due to any of the above, please explain why you needed this  
procedure? \_\_\_\_\_

3) **Please provide Claim Number(s) or Dates of Service** \_\_\_\_\_  
(**or** include a copy of your EOB) \_\_\_\_\_

4) **HOW** did this injury occur? Explain/details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) **WHEN** did this injury occur? **DATE:** \_\_\_\_\_

**Continue on other side**

6) **WHERE** did this injury occur? \_\_\_\_\_

\_\_\_\_\_

**PLACE** \_\_\_\_\_

7) **WHAT** are your injuries? \_\_\_\_\_

\_\_\_\_\_

8) Have you or do you plan to retain an Attorney to file a claim against another party involved in this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please provide Name, Address & Phone # of your Attorney:

\_\_\_\_\_

\_\_\_\_\_

9) Has this case already been settled? Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, When \_\_\_\_\_

**\*** If you decide to pursue legal action, you **MUST** notify The Fund immediately or your benefits may be denied.

The information provided on this form is true and complete to the best of my knowledge.

Signature of:

Member: \_\_\_\_\_ Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax this form to the address above Attention: CLAIMS DEPT.  
so that your claims can be processed in a timely manner.