

**Initial Accident - Injury – Illness
Questionnaire**

Mail to:

**Municipal Health Benefit Fund
PO Box 188
North Little Rock, AR 72115
(501) 374-3484 (phone)
(501) 537-7252 (fax)**

This form must be filled out completely by the Member/Employee before claim can be considered for processing. Thank you.

Member Name: _____

Member ID#: _____ Member Date of Birth: ___/___/___

Member Address: _____

City & State: _____

1. This claim is being made for: ___ Self ___ Spouse ___ Dependent

2. Name: _____ Date of Birth: ___/___/___

3. Is this claim due to an accident? _____ If so, please complete the following:

A. Location of Accident: _____

B. Owner of Property: _____

Owner's Address: _____

Owner's Telephone #: _____

Please describe accident in detail: _____

4. Is this claim due to an illness or injury? _____ If so, please complete the following:

Describe illness or injury in detail: _____

(Please complete other side)

5. Is this Member covered by any other insurance? _____ If so, please list below:

Name of Insurance Co.: _____

Address: _____

Other Insurance Group and ID #: _____ / _____

6. If married, is your Spouse employed? _____ If so, please fill out the following:

Name of Spouse: _____

Employer: _____

Employer address: _____

Is this claim the result of a work related illness or injury? _____

If so, you must file with your Workers Compensation Carrier first

Is this claim the result of an MVA? _____

If so, please be sure to file with your Auto Insurance first.

7. Member/Employee Signature: _____

Date signed: _____

By signing above, I hereby present this claim and authorize any individual and/or organization to release information required for its acceptance.