LINECO
LINE CONSTRUCTION BENEFIT FUND

NECA

HEALTH AND WELFARE
BENEFITS FOR YOU
AND YOUR FAMILY

Incident Questionnaire

Today's date: _____
Member name: _____
Member ID number: _____
Patient name: _____
Relationship: _____
Birth date of patient: _____
Patient's phone number: _____

Patient name and address
_____
_____
_____
_____

Date of Incident: _____
Location of Incident: _____

Our records show that services this patient received could be related to an accident or injury. Claims cannot be processed until this incident questionnaire is fully completed, signed and returned. **Failure to return the questionnaire will result in denial of the claim.**

No benefits are payable by this Plan for any injury or sickness for which there is other non-group coverage through an automobile insurance policy or plan providing medical, sickness, or similar payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to this Plan. ***Please contact us prior to settlement.***

Required: Briefly describe the circumstances that caused the onset of symptoms:

Was this claim related to an incident/ accident?
☐ Yes ▶ Complete all sections that apply to this accident or injury, sign and date form, and return by fax or mail
☐ No ▶ Skip to the bottom of page 2 to sign and date the form, and return by fax or mail

Motor And Recreational Vehicle

Vehicle involved: ☐ Car ☐ Motorcycle ☐ Watercraft ☐ Recreational vehicle (camper, dirt bike, ATV, etc.) Does this vehicle have coverage Yes ☐ No ☐

Was the patient: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other

List any other member of patient's family injured in this accident:

Name _____ Injuries _____

Name _____ Injuries _____

Patient's vehicle insurance carrier _____ Policy number _____

Adjuster _____ Phone _____ Claim number _____

Does the policy include Personal Injury Protection (PIP) or Medical Payment (MedPay) coverage?

☐ Yes ☐ No

Responsible Insurance Company (IF NOT LINECO MEMBER)

Name of driver _____

Vehicle insurance carrier _____ Policy number _____

Adjuster _____ Phone _____ Claim number _____

Has the patient received a bodily injury settlement? ☐ Yes ☐ No Date of settlement _____

Have you filed or do you intend to file a claim? ☐ Yes ☐ No

If no, please explain _____

Has The Patient Received A Bodily Injury Settlement

☐ No settlement ☐ Yes Date of settlement_____ Settlement amount_____

If the patient was a passenger:

Driver _____

Driver's vehicle insurance carrier _____ Policy number_____

Adjuster _____ Phone_____ Claim number _____

On The Job Injury Or Illness

Did this condition or injury occur on the job or as the result of employment? ☐ Yes ☐ No

Is patient self-employed, owner, or sole proprietor? ☐ Yes ☐ No

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No Claim number *(required)* _____

What is the status of the Workers' Compensation claim? ☐ In review ☐ Accepted ☐ Denied ☐ Appealing

If a Workers' Compensation claim has been filed and denied, please include a copy of the denial letter and the first report of injury.

Workers' Compensation Carrier- _____

Adjuster _____ Phone_____

Commercial/Property Injury

Did accident or injury occur on patient's own property? ☐ Yes ☐ No *(if no, please complete the following)*

Business or property owner _____

Have you filed an insurance claim with the at-fault party? ☐ Yes ☐ No

(Medical malpractice, slip and fall, product liability, product recall, another person's home or business, assault, etc.)

If no claim filed, please explain why _____

At fault party's insurance carrier (if known) _____ Policy number _____

Adjuster _____ Phone _____ Claim number _____

Attorney Information

Have you retained an attorney? ☐ Yes ☐ No *(if yes, please complete the following)*

Attorney _____ Phone _____

Mailing address _____

If you hire an attorney, contact LINECO immediately.

I agree that any property/casualty, automobile, or workers' compensation carrier or governmental agency attorney may release any personal health information about me related to this accident to LINECO. This authorization is valid during the subrogation process.

I certify that the information on this form is true and accurate to the best of my knowledge—Member Signature Required.

Member (please print) _____ Phone_____

Signature _____ Date _____

Please submit completed form by:

Fax: (630)-916-6847

Mail: 821 Parkview Blvd., Lombard, IL 60148

Member Service: 800-323-7268