Alaska United Food and Commercial Workers Trust Funds

Physical Address 7525 SE 24th Street Suite 200 Mercer Island, WA 98040 • Mailing Address PO Box 34203 Seattle, WA 98124
Phone (206) 441-7574 or (800) 478-8329 • Fax (206) 441-9110 • Website www.akufcwtrust.com
Administered by
Welfare & Pension Administration Service, Inc.

Date:

Patient Name:
Address:

Member Name:
WPAS ID:

'IMMEDIATE ACTION IS REQUIRED'

We have received a claim for treatment on _____.
The condition being treated is a _____.
Since this condition could be injury related, we need you to please answer the following questions. **Your claim cannot be processed without this information. This information cannot be taken over the phone.**

A. Check which instance applies to the injury/condition:

☐ Motor vehicle accident
☐ Work-related
☐ Home-related
☐ Product Liability ☐ Other _____

B. Is the condition/injury the result of practice for, travel to, or travel from intercollegiate competition as a team member, or participation in any intercollegiate, semiprofessional or professional sport.

☐ Yes ☐ No

C. Briefly describe how the injury happened:

D. Give Date _____ and time _____ (AM ☐ PM ☐) of injury.

E. Name of person responsible for the injury? (If yourself, say so) _____
_____

If you have received or expect to receive reimbursement from any insurance, excluding this coverage, please answer the following:

F. Have you made a claim for reimbursement? ☐ Yes ☐ No
If yes, have you received any restitution of settlement? ☐ Yes ☐ No
If yes, when? (give date) _____. Amount of settlement was $_____
Was it a final settlement? ☐ Yes ☐ No
If you received some other type of restitution, please describe: _____

G. Please complete the following:

1. Provide name and address of the insurance company of the party or person responsible for the accident:

   Agent Name _____ Phone No _____
   Insured party or person name _____

2. Name and address of your automobile, homeowners, or similar policy.

   Agent Name _____ Phone No _____
   Insurance Claim Number_____

3. Do you have Personal Injury Protection coverage on your automobile coverage? ☐ Yes ☐ No
   If yes: you need to file a claim with them.
   If no: **please provide us with a copy of the signed waiver or declaration page from your policy.**

4. If a motor vehicle accident, were you a passenger? ☐ Yes ☐ No
   If yes: please provide the Name and address of the automobile insurance that covers the driver of the car you were riding. _____
   _____
   Agent Name _____ Phone No _____

5. Do they have Personal Injury Protection coverage on their automobile coverage? ☐ Yes ☐ No
   If yes: you need to file a claim with them.
   If no: please provide us with a copy of the signed waiver or declaration page from their policy.

6. Was a police report filed? ☐ Yes ☐ No **(If yes, please attach a copy to this form upon return.)**

H. If the condition was related to your employment, please indicate if you were:

1. Working for an employer. (If so, give name and address) _____
   _____
2. ☐ Self-employed _____
3. ☐ Working for any other person for wage or profit
   Give name and address and explain. _____
   _____

I. If you have an attorney representing you in obtaining settlement or restitution in regards to this injury, however it occurred, please give:
Attorney Name: _____ Phone No.: _____
Street Address: _____ City_____ St.___ Zip_____

The undersigned agrees to cooperate fully with the Plan in asserting its rights under this subrogation agreement and to supply the Plan with any and all information and execute any and all instruments that the Plan reasonably needs for that purpose.

I certify the foregoing statements are true, correct and complete. I further authorize the hospital, physician or other health provider to furnish and disclose to Welfare and Pension Administration Service any and all facts concerning my condition that are within their knowledge. A copy of this authorization is to be considered valid for that purpose.

Insured Signature_____ Date_____

Patient Signature_____ Date_____
(If not minor child)

WPAS Employee Benefit Department **Email: claimstatus@wpas-inc.com**