

# Plumbers & Pipefitters Local 344 Health & Welfare Fund

8441 Gulf Freeway Suite 304 · Houston, TX 77017  
Phone (713) 643-9300 · 866-236-3148 · Fax (866) 316-4794

## Injury Report

**All questions must be completed by the Participant.**  
**If any of the questions do not apply, please indicate so by answering with an N/A for not applicable. Please return the signed form to the address listed above or fax to 1-866-316-4794**

*Please complete the following questions.*

Participant's name \_\_\_\_\_ Phone No. \_\_\_\_\_ UID or SSN \_\_\_\_\_

Patient's name \_\_\_\_\_ Date injury occurred \_\_\_\_\_

Please describe how, when and where injury occurred \_\_\_\_\_  
\_\_\_\_\_

Did this injury occur as a direct result of your employment and while on the job?      Yes      No

**If yes, return this form and file any related claims directly with your employer's worker's compensation carrier.**

*Please complete the following questions if the injury was the result of an automobile accident or other incident caused by a third party. No claims can be processed until all information requested below is received.*

Please list name(s) of other party(ies) involved in the incident \_\_\_\_\_

Insurance company of other party \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_ Claim No. \_\_\_\_\_

Were police called?      Yes      No      Was accident report completed by police?      Yes      No

*If a report was completed, please attach a copy to this form.*

Were charges lodged against you?      Yes      No

Were charges lodged against the other party?      Yes      No

Have you hired an attorney to represent you in this matter?      Yes      No

If yes, attorney's name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_