HEALTH & WELFARE TRUST FUND

CENTRAL STATES JOINT BOARD

Subro Response Unit

P.O. BOX A3375 ● CHICAGO, IL 60690 ● PHONE & FAX: (312) 757-5463 ● CSJBSUBRO.COM

QUESTIONNAIRE

1. Please provide the information requested below about yourself.		
If you have previously completed a form for this claim, please check here and update.		
Name:		Date of Birth:
Home Address:		
City:	State:	Zip Code:
Phone:	Email:	
I am the: Participant (Insurance Holder) Spouse Child Other Dependent		
If you are not the Participant, please provide the following information:		
Participant's Name:		Date of Birth:
ID #:		
2. Please provide the following information as to why medical treatment was received. Injury* Illness Medical Condition Regular Medical Checkup Other ______________________		
*Date of Injury:	Location of Injury:	
Type of Injury: Auto/Motorcycle Accident Work Related Accident Other		
Was this injury caused by a Third Party? Yes No		
Was a police report filed? Yes* No ***If yes, please submit a copy of the police report.**		
3. Please briefly describe the circumstances surrounding the Injury and medical treatment received.		
4. Have you received or are you attempting to receive compensation for your injuries? Yes No		
5. Have you retained an attorney to assist you in recovering part or all of the losses you sustained as a result of the Injury? Yes* No ***If yes, please provide the following information.**		
Attorney's Name:		Law Firm:
Address:		
City:	State:	Zip Code:
Phone:	Email:	
6. If you submitted a claim to any insurance (Auto, Home, Renters), or if a Third Party is responsible for your injury, please provide the following insurance information:		
Name of Insurance:		Claim #:
Address:	State:	Zip Code:
Policy #:	Phone:	Email:

I hereby certify that to the best of my knowledge and under the penalty of law, the information provided herein is true, correct and complete. I understand that providing false information may lead to refusal of this claim.

Participant Signature:

____ Date: ____________________

Dependent Signature (if applicable):

____ Date: ____________________

Parent or Legal Guardian (if Dependent is a Minor):

____ Date: ____________________

Please submit a response to this Questionnaire via any of the following means:

By visiting: csjbsubro.com
By emailing: response@csjbsubro.com
By faxing: (312) 757-5463
By mailing to: CSJB Welfare, P.O. Box A3375, Chicago, IL 60690

For questions to the *Subro Response Unit* **only**, including this Questionnaire, call (312) 757-5463.
For questions about eligibility, claims and other information about your insurance benefits, call (312) 738-0822.