INTERNATIONAL ALLIANCE OF
THEATRICAL STAGE EMPLOYEES LOCAL 22
PENSION AND WELFARE FUNDS

ACCIDENTAL INJURY QUESTIONNAIRE

Participant's Name: _____ Member ID or SSN: _____

Patient's Name: _____ Relationship: _____

Provider(s) of Service: _____

Date(s) of Service: _____

Type of Injury: _____

Additional information is needed regarding this claim. Please complete this questionnaire and return in the enclosed envelope.

When did the accident happen? _____
(**Please give date and approximate time of accident)**

Exactly where did the accident happen? _____

Was the person hurt on the job? (check one) ☐ YES ☐ NO

If yes, was a Worker's Compensation Claim filed? (check one) ☐ YES ☐ NO

How did the accident happen? _____

_____

_____

_____

_____

Please indicate the name and telephone number of an authorized family member that can be contacted between 7:30 a, and 5:30pm, if more information is needed regarding this claim.

_____ _____
Name of contact person **Telephone Number**

_____ _____
Participant's Signature **Date**

Administrator:
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6525 Centurion Drive
Lansing, Michigan 48917-9275
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