



**GREATER ST. LOUIS CONSTRUCTION LABORERS  
WELFARE FUND**

Questionnaire of Injury or Illness

Member Name:

Address:

ID#:

Injured Name:

Injury/Illness:

Approximate Date of Onset:

As you know, the Welfare Plan excludes claims related to injuries/illnesses that arise out of employment or self-employment. The Fund Office has received inconsistent or incomplete information about the cause of your injury/illness. The Greater St. Louis Construction Laborers Welfare Fund will use the information provided on this questionnaire to determine whether your claims related to your injury/illness will be considered. It is very important that you answer these questions fully and accurately.

1. Describe in detail how the injury/illness occurred. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Where did the injury/illness occur? \_\_\_\_\_

\_\_\_\_\_

3. Date of injury/illness onset. \_\_\_\_\_

4. Name and address of your employer at the time your injury/illness occurred.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Did your injury/illness occur at work?  Yes  No

6. Did you inform your doctor your injury/illness occurred at work?  Yes  No

If so, what is that doctor's name, address and phone number?

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7. Has any doctor told you your injury/illness was related to your employment?

Yes  No

If so, what is that doctor's name, address and phone number? \_\_\_\_\_

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8. Did you report the injury to your employer?  Yes  No

9. Date you reported the injury to your employer? \_\_\_\_\_

10. Did your injury occur while you were engaged in self-employment for pay, profit, or gain?  Yes  No

If so, describe the type self-employment you were engaged in.

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11. Have you filed a claim for worker's compensation benefits with respect to that injury?  Yes  No

12. Do you intend to file a claim for worker's compensation benefits with respect to that injury?  Yes  No

If not, why not? \_\_\_\_\_

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13. Have you consulted or hired a lawyer to represent you with regard to a worker's compensation claim for that injury? O Yes O No  
If so, what is the name, address and phone number of that attorney?

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If you have consulted or retained an attorney, complete the attached Authorization to Attorney to Release Information, have it notarized and return it to the Fund Office along with this completed Questionnaire.

I swear that the information I have set out in answer to this Questionnaire is true and correct, to the best of my knowledge. I understand that the Welfare Fund staff will rely on this information to decide whether my claims related to the injury or illness described above, are covered.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Member Printed Name

\_\_\_\_\_  
Date



**Authorization to Attorney To Release Information**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_,  
(Fill in your name) (Fill in name of Attorney)

To release to the Greater St. Louis Construction Laborers' Welfare Fund, its employees, and its attorneys, Hammond, Shinnars, Turcotte, Larrew P.C., any and all information regarding \_\_\_\_\_ which occurred on or about  
(Briefly describe injury or illness)

\_\_\_\_\_, and regarding any claims I may have arising from that  
(Date of injury or illness)

injury or illness or claims we considered asserting as a result of that injury or illness. I specifically authorize the release of confidential medical information and information subject to the attorney-client privilege.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Member Printed Name

\_\_\_\_\_  
Date

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned notary public, personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the within instrument and acknowledged that \_\_\_\_\_ executed the same for the purposes therein contained. In witness whereof, I hereunto set my hand and official seal.

\_\_\_\_\_  
NOTARY PUBLIC