STATEMENT OF FACTS

If you need assistance completing this form, please call us at 702-733-9938.

Participant Name:	**Spouse Name:**
Social Security Number:	**Spouse Social Security Number:**

I,_____, residing at_____,
(name) (number and street)

_____,_____,
(city) (state) (zip)

request benefits under the Plan as a result of injuries suffered on_____.
(date)

	Questions ***(Please fill out form completely)***	
1	**What type of accident did you have and what type of injuries did you experience?**	
	_____	
	_____	
2	**Were any of your covered dependents involved/injured in this accident (if so, please provide their names)?**	
	_____	
	_____	
3	**What is the name, address, phone number, and insurance information of the person(s) you believe are responsible for the injuries (if known)?**	
	Responsible Party Name:	Phone Number:
	Address:	
	Insurance Company:	Policy Number:
	Address:	
	Phone Number:	Claim Number:
4	**What is the name, address and phone number of your attorney, if you have one?**	
	Name:	Phone Number:
	Address:	
5	**Check <u>ONE</u> of the below:**	
	☐ I do not intend to make a claim or file a lawsuit against the other person(s) or their insurance or any other insurance.	
	☐ I intend to make a direct claim or lawsuit against the other person(s) responsible and do <u>not</u> wish to make a claim with the Culinary Health Fund at this time.	
	☐ I intend to make a claim against the person(s) or their insurance or some other insurance. In the meantime, I wish to have the Culinary Health Fund process my medical claims. ***(If you check this answer, please read the attached document titled "Overview of Repayment Process." You must also complete and submit the enclosed Repayment Agreement before any medical bills will be processed.)***	

I certify that the above information is true and complete to the best of my knowledge. I understand that providing false information may lead to refusal of this claim. I also understand that if my answer to the above question 5 changes after I submit this form, I must contact the Culinary Health Fund and complete a Repayment Agreement if applicable.

Signature of Injured Party: _____ **Date:** / /

Signature of Parent/Guardian:
(If injured party is a minor) _____ **Date:** / /