NECA-IBEW WELFARE TRUST FUND

2120 Hubbard Avenue, Decatur, Illinois 62526 Phone: (217) 875-0254 or 800-765-4239

EMPLOYEE STATEMENT FOR ACCIDENT

1. Employee's social security no	No	ite to Employee: You must co	omplet	e this	sia	e for any accide	nt ior	your ae r	pendent cinia.	
3. Address: Sex: Sex: F Local Union #: Phone #: Sex: F Local Union #: Phone #: Phone #: Sex: F Local Union #: Phone #: Sex: Phone #: Sex: F Local Union #: Phone #: Phone #: F Local Union #: Phone #: Phone #: F Local Union #: Phone #: Phone #: F Local Union #: Phone #: Phone #: F Local Union #: Phone #:	1.	Employee's social security no.			distribution of the					Ministeriores
4. Birth date: Sex: M F Local Union #: Phone #: 5. Information on the person who claim is for: Name Relationship to Employee Soc. Sec. # Date of Birth Sex	2.	Employee's name:				nooleen die Toonisiele (Alle Links with in 2014 as 400 Alle College on 100 Alle Colleg	Elizabeth de l'anno de l'a			***************************************
Soc. Sec. # Date of Birth Sex Date of accident Time A.M. P.M. Where did accident occur? How did accident happen? I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this accident. I will reimburse the Fund for any overpayment made to me or in my behalf due to error on this form.	3.	Address:			_ Cit	İУ:	againmean ann ann an t-òraig air air an an t-òraig air air an an t-òraig air air an t-òraig air air an t-òraig	State: _	Zip:	***************************************
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Employee Signature Date Date	E	mployee Signature	laim Ca	nnat h	o Dr	ocassad Without Vo	ur Sian	ature	Date	parecolationsonan