AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST
560 N. Nimitz Highway, Suite 217E ▪ Honolulu, Hawaii 96817-5327
Mailing Address P.O. Box 29939 ▪ Honolulu, Hawaii 96820
Telephone (808) 275-2520 ▪Toll-Free Telephone (844) 808-2520
Facsimile (808) 275-2521
Claims Administrative Office

Date:

Participant's Name
Address
City, State & Zip Code

Re: Patient's name(s)

Dear Participant

We received information indicating that you may be in treatment for a condition that could be the result of a Workers Compensation or a Third Party Liability injury. In order for our office to determine if in fact the services are the result of a Workers Compensation or a Third Party Liability injury, please answer the following questions.

Please sign, date and return the completed form to our office at your earliest convenience within 10 days from the date of this letter.

Date and time of injury or accident (or onset of symptoms): _____

Did the injury or condition occur due to the negligence of another party? Yes ___ No ____

Is the injury related to an automobile accident? Yes _____ No _____

Was a police report filed? Yes _____ No _____ If yes, provide a copy of the police report and the city, county or state of the police where the report was filed.

If an adult, is condition/injury related to your job? Yes _____ No _____

Where did it occur? (Describe locational and provide address): _____
_____

Explain how injury occurred (attach additional pages to this notice if needed):
_____

I hereby warrant and attest that this injury, accident or condition was not caused by another party and I will not take legal action or file any suite against another party.

_____ _____/_____/_____
Participant's Signature Date