Plumbers Local 130 Welfare
Subrogation Status Form

MEMBER:			**ID No.:**
CITY:	**STATE:**	**ZIP CODE:**	**TELEPHONE NO.:**
CLAIMANT:			**SSN:**

1. Date of Accident:	**1(a). Body part(s) injured:**
1(b). Describe how you were injured:	**1(c). Where did the injury occur:**
1(d). Was this injury caused by a third party:	**1(e). If YES, give the name and address of the person(s) responsible:**
2. If this injury happened at work. please answer the following:	
2(a). Employer Name:	**2(b). Do you intend to file a Workers' Compensation case?**
3. If you have retained an attorney. please answer the following:	
3(a). Attorney:	**3(b). Name of Firm:**
	3(c). Address:
	3(d). Telephone No.:
4. If Applicable, ATTACH POLICE REPORT:	

<table>
<tr><td colspan="3">5. Please Provide the following Insurance Information</td></tr>
<tr><td rowspan="3">5(a). Insurance Co.:</td><td rowspan="3">5(b). Contact Person:</td><td>5(c). Insurance Co. Address:</td></tr>
<tr><td>5(d). Telephone No.:</td></tr>
<tr><td>5(e). Policy No.:</td></tr>
<tr><td rowspan="3">5(f). Insurance Co. of Third Party:</td><td rowspan="3">5(g). Contact Person:</td><td>5(h). Insurance Co. Address:</td></tr>
<tr><td>5(i). Telephone No.:</td></tr>
<tr><td>5(j). Policy No.:</td></tr>
<tr><td colspan="3">6. Additional Insurance Information: Please include name of insurance company and Policy No.:</td></tr>
<tr><td>6(a). Homeowner's Insurance:</td><td>6(b). Auto Insurance</td><td>6(c). Other Health Insurance:</td></tr>
<tr><td colspan="2">PARTICIPANT SIGNATURE:</td><td>DATE:</td></tr>
<tr><td colspan="2">INJURED DEPENDANT SIGNATURE:</td><td>DATE:</td></tr>
</table>