PATIENT'S REPORT OF ACCIDENTAL INJURY

Insured's Name: ____________________ Social Security No. _________________

Employer/ Company: _________________ Employer Phone __________________

Employers Address:

____

Patient's Name: _______________ Date of Birth: ________ Home #____________

Patient's Address:

____

Date of Accident: __________ Approx time of day: _________ County: __________

State: _______

Exact location of Accident:

____

(street names or highway numbers, address, city, etc.)

Describe how the Accident happened:

____

____

____

List Patient's most serious injuries:

____

Names of Witnesses to the Accident: Addresses: Phone Numbers:

____

Did any police officer investigate the accident? _____
If yes, which _____________________________

(name of law enforcement agency)

If patient went directly from accident for treatment, give name of hospital or Doctor:

____

If anyone else was injured in accident, give name(s):
____

Do you believe any person (excluding Patient's family), product or property hazard caused or contributed to Patient's injuries? ________ If so, Who or What?

____

How was such person, thing or condition responsible?
____

Have you had contact with any investigator or adjuster for the other person's firm or insurance company? ______________ If so, give approx date?
____

If applicable, give such representative's name, address and telephone number:
____

Did you give a statement to the representative? _____ Did you provide information regarding the accident? ___________ has a release been signed? ___________ If so, on what date? ____________

If applicable, the lawyer representing Patient in connection with this accident is:
____
(attorney's name) (address) (phone #)

A. Was this injury sustained at a school or while patient engaged in any athletic, sports or recreational activity? _____________________________

If Question "A" is answered YES, complete this Section"

List name of school if injury occurred at a school or at a school sponsored event:
____

Location of School: __________________________ If injury occurred at an

organized sporting event, list name of sponsor: ___________________________

Sponsors address:
____

If the injury was sustained at a commercial sporting or recreational facility, give name:
____

(name of amusement park, skating rink, etc.) *(location)*

B. Was this injury sustained at a residence?

____

If question "b" is answered YES, complete this section:

Did the injury occur at Patient's home? _______ If not, at whose residence did injury occur: _____________

Patient's relationship to the resident: ________________ Did resident have a

homeowner's or renter's liability insurance policy? __________________ Name of

Insurance Company, if one: _____________________ Policy Number: ___________

Has the patient made a claim on policy? _____________

I acknowledge that my health benefit plan is entitled to recover from any person or firm legally responsible for my injuries up to the amount of benefits the Plan pays for treatment of my injuries and I recognize that the Plan retains a lien on my claim against such responsible firm or person. I will not release any responsible party from liability without the Plan's consent.

____________ ____

(date) (to be signed by Patient, or Parent of a minor Patient)

TO AVOID DELAY IN THE PROCESSING OF YOUR CLAIM, PROMPTLY RETURN THIS COMPLETED FORM ALONG WITH A MEDICAL RECORDS AUTHORIZATION FORM

THANK YOU.