Accident Form

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Subscriber: _____ Plan Name: _____

Address: _____ Plan #: _____

City/State/Zip: _____ Subscriber ID: _____

Claimant Name: _____

STATEMENT OF INJURY/ILLNESS – CLAIMANT: _____

IMPORTANT: Please ANSWER ALL QUESTIONS completely and PROVIDE ALL DOCUMENTATION requested. Sign on the bottom of pages 1, 2 and 4. If you fail to provide all requested information/documentation and/or if you fail to sign where indicated, there will be further delay in the processing of your claims.

A. DETAILS OF INJURY/ILLNESS:

1. On _____ (Date) claimant suffered injuries at (please include address or location):

_____

_____

_____

The facts surrounding the injury are as follows:_____

_____

_____

_____

_____

2. Was this injury job related? ☐ Yes ☐ No School related? ☐ Yes ☐ No

3. Has civil or criminal action been initiated by or against claimant as a result of the incident causing the injury or illness?

☐ Yes ☐ No If "YES", please explain:_____

_____

_____

4. Has an attorney been retained by the claimant in connection with this incident? ☐ Yes ☐ No

If "YES" provide attorney's NAME, ADDRESS and PHONE NUMBER:_____

_____

_____

_____

5. I have inquired and other coverage, e.g., Workers Compensation, School, Homeowner's or other Premises insurance (liability or medical payment coverage), or Medical Malpractice insurance (☐ is) or (☐ is not) available. If available, **provide name and address of insured person**, the **insurance type**, and the **name, address, policy number and phone number of the insurance company:**

_____

_____

_____

6. Did a law enforcement officer investigate? ☐ Yes ☐ No If YES, please attach a copy of the official report of the accident/incident. For motor vehicle accidents, an Exchange Slip or Notice of Requirement is NOT sufficient. You must attach the actual police report of the accident.

Signature: _____ (Subscriber Name) _____ (Date)

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If the injury/illness/disease was not the result of an accident involving a motor vehicle, bicycle, all terrain vehicle, etc., you may skip Section B. Sign this form below in the space provided and proceed to page 4.

B. FOR AUTOMOBILE/MOTORCYCLE/BICYCLE/ALL TERRAIN VEHICLE ACCIDENTS ONLY:

1. Name, address, telephone number and policy number of CLAIMANT'S automobile insurance:

_____

_____

2. Enclose a copy of the declaration page for claimant's automobile insurance policy, regardless of who was at fault in the accident.

3. If CLAIMANT was a passenger in a vehicle registered to another person, provide the name and address of that person, and the name, address, telephone number and policy number of that person's automobile insurance company. Enclose a copy of the declaration page for that policy.

_____

_____

4. Name, address, telephone number and policy number of the insurance covering the other vehicle(s) involved in the collision.

_____

_____

5. Was claimant wearing a seatbelt? ☐ Yes ☐ No ☐ Not applicable

6. Was claimant wearing a safety helmet? ☐ Yes ☐ No ☐ Not applicable

7. Was claimant restrained in an approved child safety seat? ☐ Yes ☐ No ☐ Not applicable

The information provided on this Statement of Injury/Illness is complete and true to the best of my knowledge.

Signature: _____ _____

(Subscriber Name) (Date)

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Subscriber Name:_____

Claimant Name:_____

SUBROGATION AGREEMENT FORM

Re: **Date of Injury:**

This form must be completed, signed, and returned before any claim resulting from the above-referenced injury will be paid, whether or not an attorney has been retained

I agree that the Plan shall be subrogated, to the extent of any payments made under the Plan to or for the benefit of me or my dependents, to all of the rights of recovery of or on behalf of me or my dependents arising out of any claim or cause of action which may accrue to me or my dependents, or my or my dependent's successors in interest because of or arising as a result of any illness, injury, disease, or other condition incurred or suffered by me or my dependents for which any party may be liable or legally responsible by reason of contract, tort, or other cause of action.

I agree that any benefits paid by my health care Plan are secondary to any automobile or premises medical payment or no fault coverage that may be available. I further agree to reimburse the Plan for all benefits paid as a result of the accident from any recovery as a result of suit, settlement, or otherwise that I might have. The Plan has the right of first recovery from any such settlement or cause of action, regardless of the characterization of the damages in any settlement document, court order, or other documents.

I agree to promptly furnish the Plan Supervisor all information relevant to my right or cause of action against any third party involved in the action and to fully assist and cooperate with the Plan Supervisor in protecting the Plan's subrogation and reimbursement rights. I agree to cooperate in every way to protect the Plan's subrogation and reimbursement rights,
including claims or accident investigation, promptly and accurately completing any necessary forms or documents, keeping the Plan Supervisor informed of the name, address, and telephone number of any attorney or firm that represents me or my dependents, and instructing any such representative to fully comply with the terms of the agreement. I will not act or fail to act in any manner that would likely result in the limitation of the Plan's subrogation or reimbursement rights.

I agree to hold in trust for the benefits of the Plan any damages received by me or my agent or representative, regardless of the characterization of such damage in any settlement or other document. I agree that the Plan shall have the right of first reimbursement from any recovery my dependents or I obtain, even if my dependents or I are not made whole by such recovery. The Plan Supervisor may reduce the amount of reimbursement required from any recovery to allow for attorney fees or other costs of recovering any benefits paid by the Plan.

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If requested by the Plan Supervisor, I agree to instruct any attorney or firm that I have retained to represent me or my dependents to represent and protect the interests of the Plan. The Plan reserves the right to retain an attorney or firm separate from my attorney to represent the interests of the Plan.

If I take any action contrary to the terms of this agreement, benefits under the Plan will cease immediately.

In the event that my dependents or I receive a settlement from another person or insurance company prior to the Plan's rights being honored, the liability of the Plan shall be reduced by the amount of such settlement.

Name, address and telephone number of the attorney representing claimant for this injury:

_____

_____

Signature: _____ _____
(Date)

Signature: _____ _____
(Date)