



Employee Name: _____ Employer : _____

Certificate ID #: _____

Patient Name: _____ Patient DOB: _____

General Questions

Section 1

1. When did this incident occur?

Date: ____/____/____

2. Where did this incident occur?

3. Is this a result of an ongoing condition? If yes, please indicate date of onset.

Yes No Date: ____/____/____

4. Was this a school related injury?

Yes No

5. Was this a sport or recreational injury?

Yes No

6. Was this self-inflicted?

Yes No

The cure for benefits as usual.





7. Did this condition/incident happen while at work? If yes, was a workers' compensation claim filed?

Yes No Workers' Comp claim? Yes No

8. Please describe in detail what occurred.

Details: _____

Motor Vehicle Accident

Section 2

(Skip this section if the incident did not result from a Motor Vehicle Accident)

1. What date did the Motor Vehicle accident occur?

Date: ____ / ____ / ____

2. Was a police report filed? If yes, a copy of the police report is required.

Yes No

3. Who was at fault?

4. Were any tickets or violations issued? If yes, please provide who was cited.

Yes No Who was cited: _____

The cure for benefits as usual.





5. Was anyone involved in the accident alleged to have been under the influence of alcohol or drugs? If yes, please provide who was cited.

Yes No Who was cited: _____

6. Have you reported the accident to your motor vehicle insurance company?

Yes No

7. Please provide the name, address and policy number of your motor vehicle insurance company

Name & Address: _____

Policy #: _____

I, _____, certify that the above is true and I understand that I may be held responsible for any over-payments made on claims due to misrepresented information.

Signature

____/____/_____
Date

The cure for benefits as usual.





Subrogation

Section 3

1. Will you be seeking any third party action as a result of this accident/injury? If yes, please provide who you are taking action against.

Yes No Who: _____

2. Please provide your attorney's name and address:

Name & Address: _____

It is important that you are aware of the subrogation language in your Plan Document. Please read the following statement and sign below:

I have been made aware that the Health Benefit Program through my employer contains a subrogation provision that is designed to reimburse my employer for benefits paid where the injury or illness was caused by any other party. I agree that any monies paid for myself or my dependent(s) as a result of the injury or illness caused by the Third Party will be reimbursed to my employer up to the full amount paid by them in accordance with the Plan.

I have signed below showing that I understand and agree to the above.

Signature

_____/_____/_____
Date

The cure for benefits as usual.

