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

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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:_____

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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***

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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.