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## ACCIDENT INFORMATION REQUEST FORM

Our records show you may be suffering from an injury or illness that resulted from the actions of another party. To make sure we accurately determine your benefits, please provide the following information. ***We cannot pay claims until we receive the following information.***

Describe the injury or illness:

If you were injured, how did the accident happen?

If you were injured, where did the accident happen?

If you were injured, when did the accident happen?

Is the injury or illness related to the patient's employment? . . . . .  Yes  No

Is the injury or illness related to an automobile? . . . . .  Yes  No

If yes, who was cited by the police as being at fault? \_\_\_\_\_

You may have auto insurance that provides coverage for this accident. What is your auto insurance carrier's name, address, and policy number (or claim number)?

