INJURY/ACCIDENT QUESTIONNAIRE

ADMINISTRATORS FOR EMPLOYEE BENEFITS PLANS

Mailing Address: P.O. Box 1894 • Tacoma, WA 98401
Physical Address: 1101 Pacific Ave. Suite 300, Tacoma, WA 98402

Phone: 253.564.5611 ext. 210 • **Fax:** 253.564.5881 • **Toll Free:** 800.426.9786 ext. 210

NEW PATIENT PROFILE

Insured Name:

Address: | City: | State: | Zip:

Birth Date: | Social Security #:

Home Phone #: | Work Phone #:

Patient Name (*If other than insured*):

Address: | City: | State: | Zip:

Birth Date: | Social Security #:

Home Phone #: | Work Phone #:

INJURY/ACCIDENT DESCRIPTION

Date of Injury/Accident:

Brief description of injury/accident cause:

Other causes: *(Please check your response)*

Was injury on premises other than your own?	☐ Yes	☐ No	Was injury work related?	☐ Yes	☐ No
Was injury due to poisoning by food?	☐ Yes	☐ No	Was injury due to an act of violence?	☐ Yes	☐ No
Was injury due to poisoning by drugs?	☐ Yes	☐ No	Was injury due to a faulty product?	☐ Yes	☐ No

If you answered "yes" to any of the above questions, please provide details:
(*i.e. address where injury occurred and homeowner's insurance company name, phone number, and policy number)*

Treating Physician: | Phone #:

Address:

Patient's Attorney: | Phone #:

Address: | City: | State: | Zip:

Please provide any other information regarding this injury/accident you believe would be helpful:

INJURY/ACCIDENT QUESTIONNAIRE

IF THIS WAS AN AUTO ACCIDENT, PLEASE ANSWER THE QUESTIONS BELOW WHERE APPLICABLE. IF NOT, CONTINUE TO SIGNATURE PORTION OF FORM.

(Please check your response)

Was patient driving?	☐ Yes	☐ No	Was patient a pedestrian?	☐ Yes	☐ No
Was patient a passenger?	☐ Yes	☐ No	Was another vehicle involved?	☐ Yes	☐ No

Name of Responsible Party: | Drivers License #:

Address:

Auto insurance company for patients vehicle:

Agency Name:	Phone #:	Policy #:	
Address:	City:	State:	Zip:
Agent Name:	Agent Phone #:		

Auto insurance company for other driver's vehicle:

Agency Name:	Phone #:	Policy #:	
Address:	City:	State:	Zip:
Agent Name:	Agent Phone#:		

Police department or emergency services that rendered assistance:
(Please supply copy of police report)

Name:	Phone #:		
Address:	City:	State:	Zip:

I HAVE COMPLETED THIS QUESTIONNAIRE AND CAREFULLY READ ITS CONTENTS.
FURTHER, I ATTEST TO THE ACCURACY AND CORRECTNESS OF THE INFORMATION.

____________________ Patient or Guardian

____________________ Date

REPAYMENT AGREEMENT

I, __________________ am a participating member of the __________________ health plan and I am presenting a claim for the payment of benefits under said plan.

In consideration of my health plan paying benefits under the terms of said plan and to the extent of any benefits so paid, without limiting any rights granted the plan pursuant to the master health plan agreement, I hereby agree to subrogate said plan to any and all Third Party claims that I now have or that may arise.

In the event I recover from any party who caused or contributed to my injury or condition, I hereby agree to reimburse the plan for all benefits paid or that will be paid as a result of my injury or condition.

In the event I elect not to pursue any Party claims, my election to be indicated below, I hereby authorize said plan to pursue any such claims in my name, and I hereby agree to fully cooperate with the plan in the prosecution of any such claims.

_____ I will be pursuing a claim against the third party(s) who caused, contributed to, or aggravated my injury or condition.

_____ I will not be pursuing a claim against any third party(s).

I HEREBY WARRANT THAT I HAVE TAKEN NO ACTION TO DEFEAT THE PLAN'S SUBROGATION RIGHTS.

____________________ Signed

____________________ Date

____________________ Attorney Signature

____________________ Date