



Patient: _____ Group No: _____
Employee: _____ Acct No: _____
Claim No: _____ Incurred: _____
Provider: _____ Charge: _____

ACCIDENTAL INJURY QUESTIONNAIRE

(1) Is the above-referenced claim related to an injury sustained in an accident?
Yes / No

(If the answer to Question 1 is “No”, please skip all of the remaining questions, but sign and date this form where indicated and return it with a copy of this letter to HealthComp.)

(2) Please briefly describe the circumstances which led to your injury. (e.g. “I was in a car accident”, “I fell at home.”)

(3) What was the date of your injury?

(4) Where did the injury occur? (e.g. home, work, automobile)

(5) Did the injury occur while you were working? Yes / No

(6) Was the injury the fault of someone else? Yes / No

(7) Was a police report filed? Yes / No / Not applicable
(If “Yes”, please provide a copy of the police report)

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(8) Do you or the patient have any other insurance policy which you believe may be responsible to pay for any expenses related to this injury? Yes / No

If “Yes”, please provide the following:

What is the type of insurance (e.g. homeowners, automobile)?

Insurance Company Name: _____

Address: _____

Phone: _____

Policy # _____

Claim # _____

Policyholder’s Name: _____

(9) Is there an insurance policy issued to a person other than you whom you believe may be responsible to pay for any expenses related to this injury? Yes / No

If “Yes”, please provide the following:

What is the type of insurance (e.g. homeowners, automobile)?

Insurance Company Name: _____

Address: _____

Phone: _____

Policy # _____

Claim # _____

Policyholder’s Name: _____

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(10) Have you hired an attorney to represent the patient regarding this accident or injury?

Yes / No

If "Yes", please provide the following:

Attorney's Name: _____

Address: _____

Phone: _____

We want to inform you that in the event that an injury is related to the negligent acts of a third person or company, the Plan has the right to be reimbursed for any benefits which were paid on your behalf for care or treatment of that injury. The reimbursement must be made from any settlement, lawsuit, or claim filed by you or anyone acting on your behalf, and also applies to any spouse or dependents you may have enrolled on the Plan.

The Plan's right to reimbursement attaches to any settlement, judgment, award or any other form of compensation you receive relating to this injury, including any payment under any policy of insurance, and including any underinsured or uninsured motorist coverage you may have. The Plan's right to be reimbursed will be considered a first-dollar priority lien, and must be repaid in full. Please see your Plan Document for the full terms and conditions related to this reimbursement provision. (A copy of the relevant portions of the Plan Document will be provided to you free of charge upon written request.)

Your agreement to abide by the full terms and conditions of the Plan Document, including the Third Party Recovery (or "Subrogation") provision, is necessary in order to continue coverage for your injuries related to this accident.

I verify that the above information is true and correct to the best of my knowledge, and I have read and understood the Plan's right to be reimbursed for all benefits paid for the treatment of injuries related to this accident.

Signed: _____

Employee's Signature

Date Signed: _____

Please send the requested information to: HealthComp Administrators, P.O. Box 45018, Fresno CA 93718-5018. If you prefer, you may fax the information to us at: (559) 499-2464. If you have any questions please contact our Customer Service Department at (800) 442-7247